2010 P&G US Healthcare Plan
Summary Plan Description

Location: United States, All sites except: Alexandria, Hawaii, Iowa City (Clairol), St. Louis, & Puerto Rico

NOTE TO USER: Any words that are italicized such as *The Employee Service Center,* will be found in the back of this document under Contacts. The Glossary Section that is found in the back of this document contains definitions of *italicized words* that are also in this document.

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P&G US Healthcare Plan

Please Note: This Summary Plan Description applies to all Procter & Gamble US locations except for the following: Alexandria, Hawaii, Iowa City (Clairol), St. Louis and Puerto Rico. Refer to the Carrier's Matrix (located at the back of this document) to determine appropriate Carriers for medical, prescription, and EAP carriers for your site and to obtain provider directory information.

The P&G US Healthcare Plan provides coverage for employees and their eligible dependents. A *co-payment* applies to certain services such as physician office visits, urgent care visits, many in-patient and out-patient hospital services, and emergency room care. After applicable co-payments, and after meeting the annual *deductible*, if you use *in-network* providers, the Plan generally pays 100% of covered charges for physician office visits, urgent care visits, hospital services billed by the hospital and emergency room care. After meeting the annual deductible, if you use in-network providers, the Plan generally pays 90% (you pay 10% co-insurance) of covered charges for most other medical services up to an annual *out-of-pocket maximum*. The Plan then pays 100% of most remaining expenses for the rest of the plan year

You and your family members are **not** required to select a primary care physician (PCP) to coordinate your care. As long as you use network providers and services and follow *pre-certification* requirements, claims will be paid at the in-network rate. However, the Plan does encourage you to establish a relationship with a primary doctor who can help coordinate your care.

Note: For claims to be paid at the in-network rate, it is the responsibility of you or your dependents to determine whether a provider or service is in the network PRIOR to accessing services.

You may also use *out-of-network providers* and pay part of the costs. Once you satisfy an annual *deductible,* the Plan generally pays 70% of *reasonable and customary* expenses up to the out-of-pocket maximum. The Plan then pays 100% of most remaining reasonable and customary eligible expenses for the rest of the calendar year.

If you use a combination of both in-network services and out-of-network services for a procedure, the services rendered by in-network providers will be paid at the in-network benefits level, will be subject to the in-network deductible and will apply only to the in-network out-of-pocket maximum, while services rendered by out-of-network providers will be paid at the out-of-network benefit level, will be subject to the out-of-network deductible and will apply only to the out-of-network out-of-pocket maximum.

Certain services require pre-certification before benefits will be fully provided.

Anytime you or your dependents receive services outside the network (including travel, dependents living temporarily away from home, and emergency care), benefits will be paid at out-of-network levels and you will be responsible for out-of-network costs. If you have dependents living temporarily away from home, review the carrier's network to determine network providers available in the dependent's area, so the dependent can use an in-network provider and receive care at the in-network level.

A prescription program, administered by your Prescription Plan Carrier, allows you to purchase prescriptions at participating retail pharmacies and by home delivery. Although the prescription program is included as a package with the medical plan, **you will be required to enroll in each plan individually.** Please keep in mind that medical and prescription coverage are tied together, so it is important to keep your participant levels consistent between these plans.

Cost/Contribution

You and the Company share the cost of coverage. How much you pay depends on the coverage category you choose and the number of hours you are scheduled to work.

Health Care premiums are pre-tax and may be paid with FlexComp Credits. If your total spending for FlexComp benefits exceeds your credit, the balance will be paid via salary redirection.

If you are a *full-time* monthly-paid or *part-time* monthly-paid employee, the health care premiums are deducted from your last paycheck of the month. If you are a full-time bi-weekly paid employee, the health care premiums are deducted from your first and last paycheck of the month.

For Example: If you are paid monthly, your premium is deducted with *pre-tax*** dollars each payday. If you are paid biweekly, your premium is deducted with pre-tax** dollars on the first and last paychecks of the month (including months in which you receive three paychecks).

Note: If you are a full-time employee working a *Less Than Full Time (LTFT)* schedule, (if applicable to your site and employee status) the *Less Than Full Time (LTFT) health care premium* you pay depends on the percent of time you work.

If you are a part-time employee or an intern/co-op, the premium you pay depends on how many hours you work during your previous anniversary period. If you work:

- more than 1,000 hours per anniversary year, you pay the *Part-Time Reduced Rate*; or
- less than 1,000 hours per anniversary year, you pay the Working Rates full cost of coverage.

If you are a part-time employee, intern or co-op employee, your premium is deducted from your personal checking or savings account via direct debit, generally on the 25th of the month.

**If you enroll a *domestic partner - not a legal tax dependent*, your premiums will be deducted on an *after-tax* basis. Additionally, you will incur imputed income on the value of providing health care benefits to a domestic partner who is not your legal tax dependent. P&G will use P&G's total cost (Working Rates) for single coverage, minus the employee premium for single coverage to determine a net amount to be used for imputed income. This net amount is calculated annually and is adjusted every January 1. The imputed income amount will appear on your paycheck on the same frequency as your heath care premium. Refer to the Taxes section of the Plan for more details.

MEDICAL, EAP, AND PRESCRIPTION COVERAGE MONTHLY PREMIUM Effective: 01/01/2010	
Full-Time Employees	
Coverage Level	**Employee Premiums**
Single	$46.40
EE+1	$92.80
Family	$130.00
<1000 hours Part-Time Employees (100% including prescription)	
Coverage Level	**Employee Premiums**
Single	$435.31
EE+1	$873.27
Family	$1172.40
>1000 hours Part-Time Employees (50% including prescription)	
Coverage Level	**Employee Premiums**
Single	$240.86
EE+1	$483.04
Family	$651.20
COBRA	
Coverage Level	**Employee Premiums**
Single	$444.01
EE+1	$890.73
Family	$1,195.85
Working Rates	
Coverage Level	**Employee Premiums**
Single	$435.31
EE+1	$873.27
Family	$1,172.40

Less Than Full-Time (LTFT) Calculation for Health Care Premiums

Working rate(s)* (at appropriate coverage level - single, family, etc.)

- Full-Time Employee Premium (at appropriate coverage level - single, family, etc.)

x Co-percentage of Less Than Full Time (LTFT) (Example: If on 80% schedule, your co-percentage would be 20%)

+ Full-Time Employee Premium (at appropriate coverage level - single, family, etc.)

Monthly LTFT Premium

*If the Cost/Contribution chart separately lists Working Rates for medical and prescription coverage, you must include EACH of these amounts (at the appropriate coverage level) to calculate your **total** Working Rate.

Example:
Assume the **total** single working rate is $200, the single premium is $25 and you are working an **80% schedule**.

$200.00 (Total Single Working Rate)
- 25.00 (Single Full-Time Employee Premium)
175.00
x 0.20 (Co-percentage of 80% schedule)
35.00
+ 25.00 (Single Full-Time Employee Premium)
$60.00 Monthly LTFT Premium

Part-Time Reduced Rate Calculation for Health Care Premiums (for PT employees that have worked more than 1,000 hours in previous anniversary year)
Working rate(s)* (at appropriate coverage level - single, family, etc.)
- Full-Time Employee Premium (at appropriate coverage level - single, family, etc.)
x 50%
+ Full-Time Employee Premium (at appropriate coverage level - single, family, etc.)
Monthly Part-Time Employee Premium

*If the Cost/Contribution chart separately lists Working Rates for medical and prescription coverage, you must include EACH of these amounts (at the appropriate coverage level) to calculate your **total** Working Rate.

Example: Assume the **total** single working rate is $200 and the single premium is $25.

$200.00 (Total Single Working Rate)
- 25.00 (Single Full-Time Employee Premium)
175.00
x 0.50
87.50
+ 25.00 (Single Full-Time Employee Premium)
$112.50 Monthly Part-Time Employee Premium

Note: Part-Time Reduced Rate Health Care Premiums change whenever the Working Rates change (January 1).

Spouse/Dependent Fee When Other Coverage Is Available

When your spouse or dependent (age 19 or over) has other medical coverage available at a cost of 50% or less of the cost of that plan; and he or she chooses **not** to take single medical insurance offered to them as their primary plan, and you cover him or her under your P&G plan, **you will be charged** a monthly fee of $250 for each applicable person.

For example, if the total cost of single coverage in your spouse's/dependent's plan is $200 and your spouse/dependent must pay $101 or more for single coverage in the lowest cost plan available to them, the additional fee is waived because your spouse/dependent would be required to pay more than 50% of the total cost. However, in the same example, if your spouse's/dependent's cost was $100 or less (50% or less) of the total cost, and he/she chose not to enroll in single coverage, you would be charged an additional $250 to cover your spouse/dependent in your P&G Plan.

If you qualify for an exemption from the additional fee, you should submit a written statement from your spouse's/dependent's employer detailing the total cost of the plan and your spouse's/dependent's cost with your Health Care Enrollment/Change Form.

If you are a biweekly paid *part-time* employee (if applicable), your additional fee is deducted from your checking or savings account via direct debit, generally on the 25th of the month.

If you are a monthly paid part-time employee (if applicable), or biweekly or monthly paid *full-time* employee, your fee is deducted from your paycheck. The frequency of payroll deductions depends on your paycheck schedule. If you are paid biweekly, your additional fee is deducted with *pre-tax** dollars, spread equally over the first two paychecks of the month. If you are paid monthly, your additional fee is deducted with pre-tax* dollars each payday.

Note:
The additional $250 fee for covering your spouse or dependent who has other medical coverage available will **not** apply if:

- he or she is not yet eligible to enroll for the other medical coverage, such as having to wait for an Annual Enrollment date (note - this only applies if there have been no previous opportunities for enrollment that were not taken); or
- the cost to your spouse or dependent for the other medical coverage is **greater** than 50% of the total cost for primary single coverage.

If your spouse/dependent enrolls in his or her available medical plan, you may enroll him/her in P&G's EE+1 or family coverage using coordination of benefits.

*If you enroll a *domestic partner - not a legal tax dependent*, your additional fee will be deducted on an *after-tax* basis. Refer to the Taxes section of the Plan for more details.

Best Doctors

P&G employees are P&G's greatest asset. Best Doctors is one of several programs being provided through **P&G Vibrant Living** and represents P&G's ongoing commitment to help P&G employees and family members be as healthy as possible. Reassurance that you are doing the right things to deal with a serious medical condition provides peace of mind for you and your family.

P&G employees and eligible family members, have access to a comprehensive health benefits package with many valuable tools and resources to help you be as healthy as possible. Never is that more important than when you or a family member has just learned about a serious medical condition or illness. You need the right answers to some tough questions:
"Is there a different treatment that would be better for me?"
"Is surgery really my best option?"
"Does my current treatment plan include the very latest in medical research?"
"How can I be confident that I am making the right choice based on the best information?"

The Best Doctors program is a confidential service available at no cost for program use to eligible P&G employees and family members enrolled in the P&G U.S. Healthcare Plan. It provides easy access to an expert second opinion for those faced with serious medical conditions. When you choose to use Best Doctors, you receive a comprehensive evaluation of your medical situation by a team of medical experts.

A simple phone call to Best Doctors can move you closer to certainty. When you make the call, you will speak with a Best Doctors Member Advocate Nurse who will listen to your concerns and ask about your medical situation. With your permission, the nurse will gather all of your medical records, work with the Best Doctors Medical Team to analyze your medical condition from every angle, and identify the leading expert doctor(s) best qualified to evaluate your case. Once the expert evaluation has been completed, Best Doctors will send you and with your agreement, your doctor, your final confidential report with the answers you need. Your Member Advocate Nurse will review the report with you and answer any questions you or your doctor may have. You and if you choose, your family and doctor can confidently work together to decide the most appropriate next steps.

One phone call can get you started: (866) 904-0910.

A Best Doctors Member Advocate is ready to listen to and answer your questions concerning your medical situation and the Best Doctors service.

Blueprint for Healthy Living

Taking ownership for good physical and mental health is necessary to a good future for you and P&G. Healthy employees and families translate to a healthier company. The Blueprint for Healthy Living program is a component of the medical plan that provides employees and dependents age 18 and over with tools to assist them in achieving and/or maintaining a healthy today and many healthy tomorrows. No matter what the current state of one's health may be, this program will provide helpful information and assistance to either improve or maintain it.

The Blueprint for Healthy Living program, administered by Alere, offers a set of online tools and one-to-one discussions with a health professional to educate and empower employees and their family members to make the best possible health care and lifestyle-related choices. Your participation in the program is voluntary and confidential.

Blueprint for Healthy Living offers a comprehensive set of services:

- A Wellness Assessment tool - To address physical, emotional and lifestyle risks.
- Personal Wellness Advocacy Programs - Personal follow-up on results, education, assistance with lifestyle improvement, and 24/7 counsel from registered nurses.
- Condition Management - Participants receive individual, customized guidance related to conditions that are driving decreased quality of life, lost work time and increased health care costs. Identified conditions are: Asthma; CAD (Coronary Artery Disease); CHF (Congestive Heart Failure); COPD (Chronic Obstructive Pulmonary Disease); Depression; Diabetes; Musculoskeletal Pain.
- Your Everyday Health Sessions - Short online educational courses that cover a variety of wellness and healthcare topics that helps participants to get/stay healthy and use healthcare dollars wisely.

There is no cost to participate in Blueprint for Healthy Living. The following rewards and chances in a premium rebate drawing may be earned by active employees/eligible dependents through participation in the program components*:

- Wellness Assessment completion: $100/person, limit 1 reward/year.
- Personal Wellness Advocacy Program completion: $100/person per course, each course once per year.
- Condition Management: $200/person for on-going participation in the program, limit 1 reward/year.
- Your Everyday Health Session: $20/course, each course once per year.
- Earning a reward in any of the above offers a chance at a P&G U.S. Healthcare Benefit Plan premium rebate. Rebate is limited to full time active employee premium.
- Maximum reward per year is dependent on coverage level.
    - Single employee - $275 reward maximum per year
    - EE+1/Family - $550 reward maximum per year

Rewards for the family are paid to the employee (subscriber) through the employee's paycheck. The employee will be able to see which type of programs (e.g. Wellness Assessment, Personal Wellness Advocacy, Condition Management or Your Everyday Health) were completed and the amount of each reward earned for each type of program, but will not have access to specific condition being managed or which specific courses were completed.

***** COBRA participants are eligible to participate in all of the program components. However, there is no system available to award rewards or premium rebates to COBRA participants.

To participate in Blueprint for Healthy Living, go to *www.blueprintforhealthyliving.com* or call 1-888-216-8275 for more information.

EAP and Behavioral Health

All *behavioral health* services are coordinated by your *Employee Assistance Program (EAP)*

The EAP is a voluntary, confidential counseling program designed to assist employees and their family members. You may access the EAP whenever you experience a personal, family or work problem that may affect your health, job performance or general well-being.

The Employee Assistance Program (EAP) is the sole gateway to all behavioral health services. To receive full behavioral health benefits you **must** obtain Pre-certification with the EAP before treatment begins.

EAP counselors are available 24 hours a day, seven days a week.

Accessing EAP and Behavioral Health

Please see the *Carrier Matrix* to find the name of the carrier that administers your EAP plan. In addition, you have access to P&G Work/Life Services - a unique and confidential service designed to enhance your well-being. You should contact the EAP for all EAP services, *behavioral health* network and referrals, and Work/Life services.

When you call the EAP, you may be asked:

- your name and the name of the person seeking help;
- your address and telephone number where we can contact you confidentially;
- your member identification number for identification purposes;
- the P&G medical plan in which you participate; and
- a brief description of your concern.

Based on the initial phone assessment, you will be scheduled for an appointment as soon as possible. In most cases, care can be provided directly by an EAP counselor. If longer term or more intensive therapy is needed, you'll be referred to an EAP *network provider*. If you wish, you may choose a *non-network provider* after your initial visit. In either case, care **must** be pre-certified by the EAP in order to receive full benefits.

When There is an Emergency

Call an EAP representative, who will direct you to the care you need. All admissions must be authorized prior to receiving services. An EAP representative must be called within 48 hours of an emergency admission to coordinate necessary *pre-certification/authorization* procedures and out-of-network claims payment.

EAP and Behavioral Health Coverage Information

You and members of your family may call the *Employee Assistance Program (EAP)* for help in dealing with a variety of issues.

These issues include, but are not limited to:

- stress, depression or anxiety;
- difficulty in completing work assignments;
- inability to concentrate;
- excessive absences;
- frequent arguments;
- concern about alcohol or drug use;
- troubled or abused children;
- marital difficulties;
- battered spouse; and
- crisis counseling (robbery, assault, death, etc).

Based on the nature of the problem, the EAP may provide some or all of the following services:

- problem assessment and short-term counseling (up to ten sessions when approved by the EAP);
- referral to specialized care (ie. Psychologist or psychiatrist). A *co-payment* or *co-insurance* will apply. See your medical plan - Coverage Information - for details;
- therapeutic programs to help reduce stress and improve coping skills; and
- treatment referral for alcohol and drug dependency.

All *behavioral health* services cases will be care managed by EAP counselors. Care management helps ensure that you receive high quality care.

EAP counselors are trained to help you handle different types of problems. However, it is up to you to decide whether to follow any advice given by a counselor. If a problem affects your job performance, your manager may refer you to the EAP.

P&G Work/Life

P&G Work/Life Services, provided by the Employee Assistance Program (EAP) allows you to confidentially respond to questions and come up with solutions that fit your individual needs. P&G Work/Life Services covers various topics from problem areas such as stress, depression or anxiety, to personal growth areas like time management and general fitness. You can choose among programs that have three minutes worth of information to three months working with a personal coach.

What's available:

- Educational and Personal Development Programs
- Customized Self-Assessments
- Personal Plan
- Coached Series
- Resources Information
- Career Enhancement Corner

You may access these services by calling your *EAP* or by logging onto your EAP Provider's website.

Benefit Amount (What's Covered)

The amount the Plan pays toward your expenses depends on the type of care, where the care is received and who provides the care.

Should you need *emergency* care in a sudden and serious situation, and you are out-of-network, benefits will be covered as if you were in-network. *Urgent care* services will be covered if services are not available from your primary physician. Your plan will not cover emergency room services for non-emergency situations.

The Plan also includes certain coverage limitations and exclusions.

Coverage Information

The following is a list of services covered under this Plan. However, not all covered items are listed. Check with your Medical Carrier to confirm whether a particular service is covered.

Certain services require *pre-certification* before benefits will be provided. Services listed under the Inpatient Hospitalization section requires pre-certification by event, not by individual service. For example, Inpatient Hospitalization requires one pre-certification per admission - separate pre-certification would not be required for x-rays or lab tests, etc., during that hospitalization.

Inpatient hospitalization co-payments are required per hospital admission, not per individual service. For example, if you are hospitalized on an inpatient basis, you would be required to pay one co-pay for that hospital admission. You would not be required to pay a separate co-pay for each service received (i.e., Anesthesia, Operating Room, etc.) during that hospital admission.

COVERAGE INFORMATION OVERVIEW		
Description	**Benefits: In-Network**	**Benefits: Out-of-Network**
Annual Deductible	$275/Single; $550/EE+1/Family for the plan year. Co-pays do not apply to the deductible.	$550/Single; $1100/EE+1/Family for the plan year. Co-pays do not apply to the deductible.

Annual Out-of-Pocket Maximum	Maximum: $1,350/Single; $2,700/EE+1/Family The following applies to in-network out-of-pocket maximum: *in-network co-pay (except infertility) *in-network co-insurance (except infertility and retail/home delivery prescription medications). *in-network deductible	Maximum: $2,250/Single; $4,500/EE+1/Family The following applies to out-of-network out-of-pocket maximum: *out-of-network co-pay (except infertility and out-of-Organ Transplant Network-organ transplants) *out-of-network co-insurance (except infertility, out-of-Organ Transplant Network-organ transplants, and retail/home delivery prescription medications) *out-of-network deductibles.
Emergency Room Care for a Sudden Serious Illness or Injury that Requires Hospital Services	For emergency conditions only. No coverage for non-emergency use of ER. Certification required within 2 business days of admission for emergency admission. $100 co-pay for emergency room visit facility charges then after annual deductible, 100% of covered charges for emergency room visit facility charges and 90% of covered charges for services billed separately. Emergency Room co-pay waived if admitted.	For emergency conditions only. No coverage for non-emergency use of ER. Certification required within 2 business days of admission for emergency admission. $100 co-pay for emergency room visit facility charges then after annual deductible. 100% of covered charges for emergency room visit facility charges and 90% of covered charges for services billed separately. Emergency Room co-pay waived if admitted.
Hospital Care - Inpatient	Pre-certification required. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid. $250 inpatient hospitalization co-pay for services billed by the facility then after annual deductible, 100% of covered charges for services billed by the facility and 90% of covered charges for services billed separately.	Pre-certification required. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid. 70% of covered charges after annual deductible.

Hospital Care - Outpatient - Surgery Facility	$150 outpatient hospitalization co-pay for services billed by the facility then after annual deductible, 100% of covered charges for services billed by the facility and 90% of covered charges for services billed separately.	70% of covered charges after annual deductible.
Lifetime Maximum Benefit	**Maximum:** Unlimited. Benefit-specific limits may apply.	**Maximum:** Unlimited. Benefit-specific limits may apply.
Organ Transplants - Hospital Care - Inpatient	Inpatient hospitalization co-pay for services billed by hospital then after annual deductible, 100% of covered charges for services billed by hospital and 90% of covered charges for services billed separately. Includes but not limited to: Bone Marrow - Allogenic for certain diagnosis, Bone Marrow - Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. Any transplant not listed above but required by law or approved the plan.	70% of covered charges after annual deductible. Includes but not limited to: Bone Marrow - Allogenic for certain diagnosis, Bone Marrow - Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. Any transplant not listed above but required by law or approved the plan.

Organ Transplants - Outpatient	Outpatient hospitalization co-pay for services billed by hospital then after annual deductible, 100% of covered charges for services billed by hospital and 90% of covered charges for services billed separately. Includes but not limited to: Bone Marrow - Allogenic for certain diagnosis, Bone Marrow - Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. Any transplant not listed above but required by law or approved by the plan.	70% of covered charges after annual deductible. Includes but not limited to: Bone Marrow - Allogenic for certain diagnosis, Bone Marrow - Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. Any transplant not listed above but required by law or approved by the plan.
Organ Transplants - Physician Services	Co-pay (generalist or specialist) for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital.	70% of covered charges after annual deductible.
Physician Office Visit - Generalist	$15 co-pay for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges.	70% of covered charges after annual deductible.
Physician Office Visit - Specialist	$25 co-pay for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges.	70% of covered charges after annual deductible.

Prescription Medications - Level I - (Prescription medications primarily used to treat pain or preserve or restore body functions that are essential to life)	**Retail:** 100% of covered charges after 30% employee co-insurance ($3 minimum, $50 maximum) per prescription. **Home Delivery (Mail Order):** 100% of covered charges after 30% employee co-insurance ($3 minimum, $150 maximum) per prescription. **Maximum: 34-days supply for Retail. 90-days supply for Home Delivery.**	**Retail:** 100% of covered charges after 30% employee co-insurance ($3 minimum, $50 maximum) per prescription. **Home Delivery (Mail Order):** 100% of covered charges after 30% employee co-insurance ($3 minimum, $150 maximum) per prescription. **Maximum: 34-days supply for Retail. 90-days supply for Home Delivery.**
Prescription Medications - Level IA (Prescription medications primarily used to treat Asthma, Diabetes, Hypertension and High Cholesterol)	**Retail:** 100% of covered charges after 15% employee co-insurance ($3 minimum, $50 maximum) per prescription. **Home Delivery (Mail Order):** 100% of covered charges after 15% employee co-insurance ($3 minimum, $150 maximum) per prescription. **Maximum: 34-days supply for Retail. 90-days supply for Home Delivery.**	**Retail:** 100% of covered charges after 15% employee co-insurance ($3 minimum, $50 maximum) per prescription. **Home Delivery (Mail Order):** 100% of covered charges after 15% employee co-insurance ($3 minimum, $150 maximum) per prescription. **Maximum: 34-days supply for Retail. 90-days supply for Home Delivery.**
Prescription Medications - Level II - (Prescription medications that are not primarily used to treat pain or preserve or restore function of life-essential body functions and not primarily used to enhance lifestyle related activities such as sexual performance, dieting and smoking cessation)	**Retail:** 100% of covered charges after 50% employee co-insurance ($3 minimum, no maximum) per prescription. **Home Delivery (Mail Order):** 100% of covered charges after 50% employee co-insurance ($3 minimum, no maximum) per prescription. **Maximum: 34-days supply for Retail. 90-days supply for Home Delivery.**	**Retail:** 100% of covered charges after 50% employee co-insurance ($3 minimum, no maximum) per prescription. **Home Delivery (Mail Order):** 100% of covered charges after 50% employee co-insurance ($3 minimum, no maximum) per prescription. **Maximum: 34-days supply for Retail. 90-days supply for Home Delivery.**

Prescription Medications - Specialty Pharmacy Program	Level I -100% of covered charges after 30% employee co-insurance ($3 minimum, $25 maximum) per prescription. Level IA – 100% of covered charges after 15% employee co-insurance ($3 minimum, $25 maximum) per prescription. Level II- 100% of covered charges after 50% employee co-insurance ($3 minimum, no maximum) per prescription. **Maximum: 34-days supply.**	Level I -100% of covered charges after 30% employee co-insurance ($3 minimum, $25 maximum) per prescription. Level IA – 100% of covered charges after 15% employee co-insurance ($3 minimum, $25 maximum) per prescription. Level II- 100% of covered charges after 50% employee co-insurance ($3 minimum, no maximum) per prescription. **Maximum: 34-days supply.**
Therapy - Occupational, Physical or Speech	Generalist co-pay for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. **Maximum: 60 visit limit per person per plan year (in-network and out-of-network combined). Limit applies to any combination of occupational, physical or speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.**	70% after annual deductible. **Maximum: 60 visit limit per person per plan year (in-network and out-of-network combined). Limit applies to any combination of occupational, physical or speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.**
Transition Benefits	N/A	**Pre-certification required for Transition Benefits.** Transition benefits may apply for certain services when a new plan is implemented (Out-of-Network care covered at Network rate for a specific service or short period when new plan is implemented where network disruption occurs).
Urgent Care Center	Specialist co-pay for urgent care visit facility charges only then after annual deductible, 100% of covered charges for urgent care visit facility charges only and 90% of other covered charges.	70% of covered charges after annual deductible.

BEHAVIORAL HEALTH TREATMENT		
Description	Benefits: In-Network	Benefits: Out-of-Network
Employee Assistance Program (EAP) Visit	Care must be accessed through the EAP. 100% of covered charges. **Maximum: Up to 10 EAP visits (as determined appropriate by EAP provider).**	N/A **Maximum: N/A**
Inpatient Services	**Pre-certification required via EAP.** After accessing care through EAP, 100% of covered charges after inpatient hospitalization co-pay for services billed by facility. 90% of covered charges for services billed separately. No deductible applied for behavioral health services. 70% in-patient coverage after inpatient co-pay and 60% for services billed separately if care is not pre-certified through the EAP.	**Pre-certification required via EAP.** After accessing care through EAP, 70% of covered charges. No deductible applied for behavioral health services. 40% coverage if care is not pre-certified through the EAP.
Outpatient Counseling Services (Does not include intensive outpatient/day treatment course of treatment)	**Pre-certification required via EAP.** After accessing care through EAP, 100% of covered charges after specialist co-pay for office visits only. 90% of other covered charges. No deductible applied for behavioral health services. 70% coverage after specialist co-pay for office visits and 60% of other covered charges if care is not certified through the EAP. Includes: Individual, Marriage (but not-pre-marital), group therapy and Family Counseling, non-physician services (i.e. LPCC/LISW).	**Pre-certification required via EAP.** After accessing care through EAP, 70% of covered charges. No deductible applied for behavioral health services. 40% coverage if care is not pre-certified through the EAP. Includes: Individual, Marriage (but not-pre-marital), group therapy and Family Counseling, non-physician services (i.e. LPCC/LISW).

Outpatient Services - Intensive Outpatient/Day Treatment Course of Treatment and In-Home Behavioral Health Treatment	**Pre-certification required via EAP.** After accessing care through EAP, 100% of covered charges after $150 co-pay per course of treatment (multiple sessions) for intensive outpatient/day treatment substance abuse and behavioral health therapy and in-home behavioral health treatment. 90% of other covered charges. No deductible applied for behavioral health services. 70% coverage after $150 co-pay per course of treatment and 60% of other covered charges if care is not pre-certified through the EAP.	**Pre-certification required via EAP.** After accessing care through the EAP, 70% of covered charges. No deductible applied for behavioral health services. 40% coverage if care is not pre-certified through the EAP.

DENTAL TREATMENT		
Description	**Benefits: In-Network**	**Benefits: Out-of-Network**
Dental Care & Anesthesia - Routine	Covered under dental plan.	Covered under dental plan.
Medical Facility Charges When Hospitalization is Medically Necessary for Covered Dental Services - Inpatient	**Pre-certification required.** Medical (Not Dental) Necessity Applies. Inpatient hospitalization co-pay for services billed by the hospital then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of covered charges for services billed separately.	**Pre-certification required.** Medical (Not Dental) Necessity Applies. 70% of covered charges after annual deductible.
Medical Facility Charges When Hospitalization is Medically Necessary for Covered Dental Services - Outpatient	Medical (Not Dental) Necessity Applies. Outpatient hospitalization co-pay for services billed by the hospital then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of covered charges for services billed separately.	Medical (Not Dental) Necessity Applies. 70% of covered charges after annual deductible.

Office Dental Treatment of Traumatic Accidental Injury to Natural Teeth, e.g. auto accident, fall, etc.	**Pre-certification required.** Medical (Not Dental) Necessity Applies. Specialist co-pay for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. Includes replacement of natural teeth. Treatment must occur within 12 months of injury.	**Pre-certification required.** Medical (Not Dental) Necessity Applies. 70% of covered charges after annual deductible. Includes replacement of natural teeth. Treatment must occur within 12 months of injury.
TMJ - Physician Services	Medical (Not Dental) Necessity Applies. Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges.	Medical (Not Dental) Necessity Applies. 70% of covered charges after annual deductible.

EMERGENCY TREATMENT		
Description	Benefits: In-Network	Benefits: Out-of-Network
Emergency Room Care for a Sudden Serious Illness or Injury that Requires Hospital Services	**For emergency conditions only. No coverage for non-emergency use of ER. Certification required within 2 business days of admission for emergency admission.** $100 co-pay for emergency room visit facility charges then after annual deductible, 100% of covered charges for emergency room visit facility charges and 90% of covered charges for services billed separately. Emergency Room co-pay waived if admitted.	**For emergency conditions only. No coverage for non-emergency use of ER. Certification required within 2 business days of admission for emergency admission.** $100 co-pay for emergency room visit facility charges then after annual deductible. 100% of covered charges for emergency room visit facility charges and 90% of covered charges for services billed separately. Emergency Room co-pay waived if admitted.
Medical Transport Services (Ambulance and Medical Transport Services Other Than Ground)	**Pre-certification required for non-emergency use of medical transport services.** After annual deductible, 100% of covered charges for medical emergencies and 90% of covered charges for authorized non-emergency use of medical transport services.	**Pre-certification required for non-emergency use of medical transport services.** After annual deductible, 100% of covered charges for medical emergencies and 70% of covered charges for authorized non-emergency use of medical transport services.

HOME HEALTH CARE		
Description	Benefits: In-Network	Benefits: Out-of-Network
Diagnostic Services; Medical Social Services; Nutritional Guidance; or Skilled Nursing Care Some Home Health Services may not be covered by the Plan. It is recommended that you complete a pre-determination of benefits by contacting the health insurance carrier.	After annual deductible, 90% of covered charges. Applies only if care in a hospital or skilled nursing facility would otherwise be required.	70% of covered charges after annual deductible. Applies only if care in a hospital or skilled nursing facility would otherwise be required.
Therapy - Occupational, Physical or Speech Some Home Health Services may not be covered by the Plan. It is recommended that you complete a pre-determination of benefits by contacting the health insurance carrier.	After annual deductible, 90% of covered charges. Applies only if care in a hospital or skilled nursing facility would otherwise be required. Maximum: 60 visit limit per person per plan year (in-network and out-of-network combined). Limit applies to any combination of occupational, physical or speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.	70% of covered charges after annual deductible. Applies only if care in a hospital or skilled nursing facility would otherwise be required. Maximum: 60 visit limit per person per plan year (in-network and out-of-network combined). Limit applies to any combination of occupational, physical or speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

HOSPICE CARE		
Description	Benefits: In-Network	Benefits: Out-of-Network
Laboratory Tests; Medical Services; Skilled Nursing Care; Therapy - Inhalation	After annual deductible, 90% of covered charges. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required.	70% of covered charges after annual deductible. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required.

Therapy - Physical or Speech	After annual deductible, 90% of covered charges. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required. Maximum: 60 visit limit per person per plan year (in-network and out-of-network combined). Limit applies to any combination of occupational, physical or speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.	70% of covered charges after annual deductible. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required. Maximum: 60 visit limit per person per plan year (in-network and out-of-network combined). Limit applies to any combination of occupational, physical or speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

HOSPITALIZATION - INPATIENT Pre-certification required for all services related to elective admission. Certification required within 2 business days of admission for emergency admission. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid.		
Description	Benefits: In-Network	Benefits: Out-of-Network
Anesthesia Supply and Administration; Bandages and Dressings; Blood Transfusions; Coronary Care; Diagnostic Tests; Electrocardiograms (EKGs); Electroencephalograms (EEGs); Hospital Care - Inpatient Supplies; Intensive Care; Laboratory Exams; Nursing Care; Operating Room Services; Oxygen Supply and Administration; Plasma Transfusion; Pre-Admission Tests; Recovery Room Services; Therapy - Physical; Therapy - Radiation; X-Rays	Inpatient hospitalization co-pay for services billed by the hospital then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of covered charges for services billed separately.	70% of covered charges after annual deductible.
Hospital Care - Inpatient Surgery - Physician Services	Inpatient hospitalization co-pay for services billed by the hospital then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of covered charges for services billed separately.	70% of covered charges after annual deductible.

Physician Visit	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.
Prescription Medications Administered During Hospitalization	Inpatient hospitalization co-pay for services billed by the hospital then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of covered charges for services billed separately. Retail prescription coverage for other covered prescription medications.	70% of covered charges after annual deductible. Retail prescription coverage for other covered prescription medications.
Semi-Private Room and Board	Inpatient hospitalization co-pay for services billed by the hospital then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of covered charges for services billed separately. Retail prescription coverage for other covered prescription medications.	70% of covered charges after annual deductible. Retail prescription coverage for other covered prescription medications.
Skilled Nursing Extended Care Facility	Pre-certification required. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid. Inpatient hospitalization co-pay for services billed by the facility then after annual deductible, 100% of covered charges for services billed by the facility and 90% of covered charges for services billed separately. Co-pay waived if transferred from inpatient hospital.	Pre-certification required. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid. 70% of covered charges after annual deductible.

ORGAN TRANSPLANTS Pre-certification required for all services related to organ transplants. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits for days not certified will be paid.		
Description	Benefits: In-Network	Benefits: Out-of-Network
Bone Marrow Search and Procurement	Inpatient or outpatient hospitalization co-pay for services billed by the hospital then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of covered charges for services billed separately. Maximum: Reasonable costs of searching for a bone marrow donor may be limited to the immediate family members and the National Bone Marrow Donor Program.	70% of covered charges after annual deductible. Maximum: Reasonable costs of searching for a bone marrow donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

Non-medical Expenses - Air or Ground Transportation From the Patient's or Family Member's Place of Primary Residence to the Hospital Where the Transplant is Performed and Back	After annual deductible, 90% of covered charges for transportation of patient and one travel companion (two for companion caregivers of a patient age 17 or under) who is traveling on the same day(s) to and /or from the site of covered services for the purposes of an evaluation, medical/surgical procedure or necessary post-discharge follow-up. Coverage includes airfare at coach rate and; or taxi or ground transportation; or personal automobile mileage reimbursement at the IRS rate for the most direct route between home and the transplant facility. Valid receipts required for reimbursement. **Maximum: Non-medical air or ground transport expenses for covered person will only be paid if covered person resides more than 100 miles from transplant facility. Non-medical air or ground transport expenses for companion(s) will only be paid if they reside more than 100 miles from transplant facility.** **Up to $10,000 in payments per transplant episode for all non-medical expenses (combined in-network and out-of-network, for covered person and all companions).**	70% of covered charges after annual deductible for transportation of patient and one travel companion (two for companion caregivers of a patient age 17 or under) who is traveling on the same day(s) to and /or from the site of covered services for the purposes of an evaluation, medical/surgical procedure or necessary post-discharge follow-up. Coverage includes airfare at coach rate and; or taxi or ground transportation; or personal automobile mileage reimbursement at the IRS rate for the most direct route between home and the transplant facility. Valid receipts required for reimbursement. **Maximum: Non-medical air or ground transport expenses for covered person will only be paid if covered person resides more than 100 miles from transplant facility. Non-medical air or ground transport expenses for companion(s) will only be paid if they reside more than 100 miles from transplant facility.** **Up to $10,000 in payments per transplant episode for all non-medical expenses (combined in-network and out-of-network, for covered person and all companions)..**

Non-medical Expenses - Lodging	After annual deductible, 90% of covered charges for lodging of the patient and one travel companion (two for companion caregivers of a patient age 17 or under) who is traveling on the same day(s) to and/or from the site of covered services for the purposes of an evaluation, medical/surgical procedure or necessary post-discharge follow-up. Valid receipts required for reimbursement. Maximum: Non-medical expenses for covered person will only be paid if covered person resides more than 100 miles from transplant facility. Non-medical expenses for covered person's travel companion(s) will only be paid if they reside more than 100 miles from transplant facility. Up to $50 lodging expense per day incurred by a covered person receiving the transplant (when not hospitalized) and up to $50 lodging expense per day for covered person's travel companion(s). Lodging coverage for travel companion(s) is limited to a total of one room. Up to $10,000 in payments per transplant episode for all Non-medical expenses (combined in-network and out-of-network, for covered person and all companions.)	70% of covered charges after annual deductible for lodging of the patient and one travel companion (two for companion caregivers of a patient age 17 or under) who is traveling on the same day(s) to and/or from the site of covered services for the purposes of an evaluation, medical/surgical procedure or necessary post-discharge follow-up. Valid receipts required for reimbursement. Maximum: Non-medical expenses for covered person will only be paid if covered person resides more than 100 miles from transplant facility. Non-medical expenses for covered person's travel companion(s) will only be paid if they reside more than 100 miles from transplant facility. Up to $50 lodging expense per day incurred by a covered person receiving the transplant (when not hospitalized) and up to $50 lodging expense per day for covered person's travel companion(s). Lodging coverage for travel companion(s) is limited to a total of one room. Up to $10,000 in payments per transplant episode for all Non-medical expenses (combined in-network and out-of-network, for covered person and all companions.)
Organ Search and Procurement	Inpatient or outpatient hospitalization co-pay then after annual deductible, 100% of covered charges for services billed by hospital and 90% of covered charges for services billed separately. Maximum: N/A	70% of covered charges after annual deductible. Maximum: Up to $25,000 in payments per transplant for search fees. Up to $50,000 in payments per transplant for procurement fees.

Organ Transplants - Hospital Care - Inpatient	Inpatient hospitalization co-pay for services billed by hospital then after annual deductible, 100% of covered charges for services billed by hospital and 90% of covered charges for services billed separately. Includes but not limited to: Bone Marrow - Allogenic for certain diagnosis, Bone Marrow - Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. Any transplant not listed above but required by law or approved the plan.	70% of covered charges after annual deductible. Includes but not limited to: Bone Marrow - Allogenic for certain diagnosis, Bone Marrow - Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. Any transplant not listed above but required by law or approved the plan.

Organ Transplants - Outpatient	Outpatient hospitalization co-pay for services billed by hospital then after annual deductible, 100% of covered charges for services billed by hospital and 90% of covered charges for services billed separately. Includes but not limited to: Bone Marrow - Allogenic for certain diagnosis, Bone Marrow - Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. Any transplant not listed above but required by law or approved by the plan.	70% of covered charges after annual deductible. Includes but not limited to: Bone Marrow - Allogenic for certain diagnosis, Bone Marrow - Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. Any transplant not listed above but required by law or approved by the plan.
Organ Transplants - Physician Services	Co-pay (generalist or specialist) for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital.	70% of covered charges after annual deductible.

OTHER SERVICES		
Description	**Benefits: In-Network**	**Benefits: Out-of-Network**
Acupuncture	Specialist co-pay for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. Must be performed by licensed Acupuncturist or MD.	70% of covered charges after annual deductible. Must be performed by licensed Acupuncturist or MD.
Adult Diapers Prescribed to Treat Medical Condition	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.

Assisting Surgeon's Fees / Physician's Assistant / Nurse Practitioner	Co-pay (generalist or specialist) for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. Co-pay does not apply to assisting surgeon, physician assistant or nurse practitioner services in a hospital.	70% of covered charges after annual deductible.
Chiropractors	Generalist co-pay for chiropractor visits only then after annual deductible, 100% of covered charges for chiropractor office visits only and 90% of other covered charges. **Maximum: 20 visit limit per person per plan year (in-network and out-of-network combined).**	70% of covered charges after annual deductible. **Maximum: 20 visit limit per person per plan year (in-network and out-of-network combined).**
Circumcision - Adult - Physician Services	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. (See overview section for hospital inpatient and hospital outpatient coverage.)	70% of covered charges after annual deductible.
Cochlear Implants - Physician Services	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. (See overview section for hospital inpatient and hospital outpatient coverage.)	70% of covered charges after annual deductible.
Continuous Passive Motion Device	After annual deductible, 90% of covered charges. **Pre-certification Not Required. However, use of passive motion devices may not be covered by the Plan for some conditions. It is recommended that you complete a pre-determination of benefits by contacting the health insurance carrier.**	70% of covered charges after annual deductible. **Pre-certification Not Required. However, use of passive motion devices may not be covered by the Plan for some conditions. It is recommended that you complete a pre-determination of benefits by contacting the health insurance carrier.**

Diabetes Education	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.
Disposable Medical Supplies Prescribed to Treat Medical Illness or Injury	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.
Durable Medical Equipment	After annual deductible, 90% of covered charges. Includes approved repairs and replacements. Pre-certification not required. However, some durable medical equipment may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier prior to purchase.	70% of covered charges after annual deductible. Includes approved repairs and replacements. Pre-certification not required. However, some durable medical equipment may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier prior to purchase.
Durable Medical Equipment Batteries	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.
Foot Orthotic	After annual deductible, 90% of covered charges. Maximum: One pair per person per plan year in-network and out-of-network combined. Must be prescribed by physician.	70% of covered charges after annual deductible. Maximum: One pair per person per plan year in-network and out-of-network combined. Must be prescribed by physician.
Hospital Care - Outpatient - Non-Surgery	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.
Hospital Care - Outpatient - Supplies	After annual deductible, 100% of covered charges for services billed by the facility and 90% of covered charges for services billed separately.	70% of covered charges after annual deductible.
Hospital Care - Outpatient - Surgery Facility	$150 outpatient hospitalization co-pay for services billed by the facility then after annual deductible, 100% of covered charges for services billed by the facility and 90% of covered charges for services billed separately.	70% of covered charges after annual deductible.
Kidney Dialysis Facility	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.

Nursing Care	Generalist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges. Includes registered/graduate nurses (and in some cases, Licensed Practical Nurses). Does not include hospital inpatient nurses. Does not include private duty nurses.	70% of covered charges after annual deductible. Includes registered/graduate nurses (and in some cases, Licensed Practical Nurses). Does not include hospital inpatient nurses. Does not include private duty nurses.
Nutritional Supplements (All forms of Infant Formula specifically excluded)	After annual deductible, 90% of covered charges. Supplements must be the only source of nutrition available.	70% of covered charges after annual deductible. Supplements must be the only source of nutrition available.
Ophthalmologist	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges.	70% of covered charges after annual deductible.
Pain Control Clinic	After annual deductible, 90% of covered charges. **Pre-certification Not Required. However, some Pain Control clinics / services may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier.**	70% of covered charges after annual deductible. **Pre-certification Not Required. However, some Pain Control clinics / services may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier.**
Pharmacogenomic Testing	After annual deductible, 90% of covered services.	70% of covered services after annual deductible.
Post - Surgical Care	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital.	70% of covered charges after annual deductible.
Private Duty Nursing Care	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.

Prosthetic Devices / Appliances	After annual deductible, 90% of covered charges. Includes repairs and replacements. Does not include a spare prosthesis. **No Pre-certification required. However, some prosthetic devices/prostheses may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier prior to purchase.**	70% of covered charges after annual deductible. Includes repairs and replacements. Does not include a spare prosthesis. **No Pre-certification required. However, some prosthetic devices/prostheses may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier prior to purchase.**
Rehabilitation Facility (Non-Behavioral Health) - Inpatient	**Pre-certification required.** Inpatient hospitalization co-pay per admission for services billed by the facility then after annual deductible, 100% of covered charges for services billed by the facility and 90% of covered charges for services billed separately.	**Pre-certification required.** 70% of covered charges after annual deductible.
Rehabilitation Facility (Non-Behavioral Health) - Outpatient	Outpatient hospitalization co-pay for authorized course of consecutive rehabilitation then after annual deductible, 100% of covered charges for authorized course of consecutive rehabilitation. Generalist co-pay per visit for therapies billed separately from facility fee then after annual deductible, 100% of covered charges for therapies billed separately from facility fee.	70% of covered charges after annual deductible.
Sleep Disorder Treatment	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.
Surgeons	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. (See overview section for hospital inpatient and hospital outpatient coverage.)	70% of covered charges after annual deductible.

Surgery - Breast Reduction Surgery - Physician Services	**Pre-certification required.** Specialist co-pay for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. For treatment of medical disorder. (See overview section for hospital inpatient and hospital outpatient coverage.)	**Pre-certification required.** 70% of covered charges after annual deductible. For treatment of medical disorder.
Surgery - Cosmetic Surgery for Certain Birth Defects when Medically Necessary to Improve Function - Physician Services	Specialist co-pay for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. (See overview section for hospital inpatient and hospital outpatient coverage.) **No Pre-certification required for outpatient surgery. However, some cosmetic surgery may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier.**	70% of covered charges after annual deductible. **No Pre-certification required for outpatient surgery. However, some cosmetic surgery may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier.**
Surgery - Nasal Surgery to Correct Function - Physician Services	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. For treatment of medical disorder. (See overview section for hospital inpatient and hospital outpatient coverage.) **No Pre-certification required for outpatient surgery. However, some nasal surgery may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier.**	70% of covered charges after annual deductible. For treatment of medical disorder. **No Pre-certification required for outpatient surgery. However, some nasal surgery may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier.**

Surgery - Oral Surgery by Physician or Oral Surgeon to Treat Jaw Fracture or Dislocation - Physician Services	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. (See overview section for hospital inpatient and hospital outpatient coverage.)	70% of covered charges after annual deductible.
Surgery - Podiatry - Physician Services	Specialist co-pay for office visits only then after annual deductible, 100% of covered charges for office visits only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. (See overview section for hospital inpatient and hospital outpatient coverage.)	70% of covered charges after annual deductible.
Surgery - Reconstructive Surgery Related to a Surgical Procedure, Illness or Accident Which Would be Covered Under This Plan - Physician Services	**Pre-certification required.** Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. (See overview section for hospital inpatient and hospital outpatient coverage.) **No Pre-certification required for outpatient surgery. However, some surgery may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier.**	**Pre-certification required.** 70% of covered charges after annual deductible. **No Pre-certification required for outpatient surgery. However, some surgery may not be covered by the Plan. It is recommended that you complete a pre-determination of benefit by contacting the healthcare insurance carrier.**
Surgery - Sleep Apnea Surgery - Physician Services	Specialist co-pay for office visit only then after annual deductible, 100% of other covered charges for office visit only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. (See overview section for hospital inpatient and hospital outpatient coverage.)	70% of covered charges after annual deductible.

Surgery - Spinal Surgery - Physician Services	**Pre-certification required.** Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges. Co-pay does not apply to physician services in a hospital. (See overview section for hospital inpatient and hospital outpatient coverage.)	**Pre-certification required.** 70% of covered charges after annual deductible.
Wigs for Hair Loss Due to Chemotherapy, Radiation or Accident	After annual deductible, 90% of covered charges. **Maximum: $250 per person per lifetime for one wig only (in-network and out-of-network combined).**	70% of covered charges after annual deductible. **Maximum: $250 per person per lifetime for one wig only (in-network and out-of-network combined).**
PREVENTIVE CARE		
Description	**Benefits: In-Network**	**Benefits: Out-of-Network**
Blood Lipid Profile	100% of covered charges. Frequency based on medical guidelines for scheduled testing. Deductible does not apply.	70% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.
Chlamydia Trachomatis Screening	100% of covered charges. Frequency based on medical guidelines for scheduled testing. Deductible does not apply.	70% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.
Clinical Breast Exam	100% of covered charges. Frequency based on medical guidelines for scheduled testing. Deductible does not apply.	70% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.
Colorectal Cancer Screening	100% of covered charges. Frequency based on medical guidelines for scheduled testing. Deductible does not apply.	70% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.
Exams - Routine Eye Exams	100% of covered charges after specialist co-pay. Deductible does not apply. **Maximum: One exam per person per plan year.**	70% of covered charges. Deductible does not apply. **Maximum: One exam per person per plan year.**

Exams - Routine Gynecological Exams for All Female Members	100% of covered charges after co-pay (generalist or specialist) for office visit only. Deductible does not apply. Maximum: N/A	70% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply. Maximum: One exam per person per plan year.
Exams - Routine Physical Exams	100% of covered charges after generalist co-pay for office visit only. Deductible does not apply. For employees and dependents, as often as determined appropriate by physician. Maximum: N/A.	70% of covered charges. For employees and dependents. Deductible does not apply. Maximum: $250 charge or $175 payment, one exam per person per plan year.
Exams - Routine Well Baby Exams	100% of covered charges after co-pay (generalist or specialist) for office visit only. Deductible does not apply. Maximum: For children up to age 1, as often as determined appropriate by physician.	70% of covered charges after annual deductible. Maximum: For children up to age 1, as often as determined appropriate by physician.
Fasting Blood Glucose	100% of covered charges. Frequency based on medical guidelines for scheduled testing. Deductible does not apply.	70% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.
Immunizations	100% of covered charges after generalist co-pay for office visit only. Deductible does not apply.	70% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.
Mammography Screens for All Female Members	100% of covered charges. Deductible does not apply. Maximum: 1 total screen per physician recommendation for females age 35-39 (not annual), one screen every year per physician recommendation for females age 40 and over (in-network and out-of-network combined).	70% of covered charges. Deductible does not apply. Maximum: 1 total screen per physician recommendation for females age 35-39 (not annual), one screen every year per physician recommendation for females age 40 and over (in-network and out-of-network combined).
Osteoporosis Screening	100% of covered charges. Frequency based on medical guidelines for scheduled testing. Deductible does not apply.	70% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.

Pap Smear	100% of covered charges. As often as determined appropriate by doctor. Deductible does not apply.	70% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.
Prostate Specific Antigen	100% of covered charges. Deductible does not apply. Frequency based on medical guidelines for scheduled testing.	70% of covered charges. Deductible does not apply. Charges are not applied toward preventive care routine physical exam maximum.

REPRODUCTIVE SERVICES		
Description	**Benefits: In-Network**	**Benefits: Out-of-Network**
Birth Control Devices	50% of covered charges. Includes IUD insertion and device, dermal implant insertion and device, diaphragm fitting and device, injections. Deductible does not apply.	50% of covered charges. Includes IUD insertion and device, dermal implant insertion and device, diaphragm fitting and device, injections. Deductible does not apply.
Birthing Center/Hospital Delivery	**Pre-certification Required for hospital stay longer than 48 hours for vaginal birth or 96 hours for C-Section.** Inpatient hospitalization co-pay for services billed by the facility then after annual deductible, 100% of covered charges for services billed by the facility and 90% of covered charges for services billed separately.	**Pre-certification Required for hospital stay longer than 48 hours for vaginal birth or 96 hours for C-Section.** 70% of covered charges after annual deductible.
D&C/Abortion - Therapeutic Outpatient Surgery	Outpatient hospitalization co-pay for services billed by the facility then after annual deductible, 100% of covered charges for services billed by the facility and 90% of covered charges for services billed separately.	70% of covered charges after annual deductible.

Dependent Child Pregnancy - Hospital Care - Inpatient	**Pre-certification Required for hospital stay longer than 48 hrs for vaginal birth or 96 hrs for C-Section.** Inpatient hospitalization co-pay for services billed by facility then after annual deductible, 100% of covered charges for services billed by facility and 90% of other covered charges. Includes Pre-natal, Post-natal and Delivery Care. (Newborn of dependent not covered unless he/she qualifies as household dependent.)	**Pre-certification Required for hospital stay longer than 48 hrs for vaginal birth or 96 hrs for C-Section.** 70% of covered charges after annual deductible. Includes Pre-natal, Post-natal and Delivery Care. (Newborn of dependent not covered unless he/she qualifies as household dependent.) **Notification required for Transition Benefits.** Transition benefits: Network Rates provided if greater than 3 months into pregnancy when new plan is implemented and provider relationship has been established prior to implementation of new plan.
Dependent Child Pregnancy - Physician Services	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges. Includes Pre-natal, Post-natal and Delivery Care. (Newborn of dependent not covered unless he/she qualifies as household dependent.)	70% of covered charges after annual deductible. Includes Pre-natal, Post-natal and Delivery Care. (Newborn of dependent not covered unless he/she qualifies as household dependent.) **Notification required for Transition Benefits.** Transition benefits: Network Rates provided if greater than 3 months into pregnancy when new plan is implemented and provider relationship has been established prior to implementation of new plan.

Infertility Diagnosis and Treatment - Medical Services & Prescription Medications	After annual deductible, 70% of covered charges for medical services provided by an infertility specialist. Co-insurance does not apply to annual out-of-pocket maximum. 100% of covered charges after 50% employee co-insurance for infertility medications with no maximum co-insurance. **Maximum: $2,500 per plan year per subscriber membership for medical services (in-network and out-of-network combined). Eligibility for coverage for infertility services applies only to an employee, spouse of employee or a domestic partner of an employee. Children of employees or household dependents of employees are not eligible for infertility benefits.**	70% of covered charges after annual deductible for medical services provided by an infertility specialist. Co-insurance does not apply to annual out-of-pocket maximum. 100% of covered charges after 50% employee co-insurance for infertility medications with no maximum co-insurance. **Maximum: $2,500 per plan year per subscriber membership for medical services (in-network and out-of-network combined). Eligibility for coverage for infertility services applies only to an employee, spouse of employee or a domestic partner of an employee. Children of employees or household dependents of employees are not eligible for infertility benefits.**
Midwife Delivery in Facility	**Pre-certification Required for hospital stay longer than 48 hrs for vaginal birth or 96 hrs for C-Section.** Inpatient hospitalization co-pay for services billed by the facility then after annual deductible, 100% of covered charges for services billed by the facility and 90% of covered charges for services billed separately. No coverage for at-home deliveries.	**Pre-certification Required for hospital stay longer than 48 hrs for vaginal birth or 96 hrs for C-Section.** 70% of covered charges after annual deductible. No coverage for at-home deliveries.
Newborn Circumcision - Physician Services	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.
Newborn Hospitalization	**Pre-certification Required for newborn hospital stay longer than mother.** Inpatient hospitalization co-pay for services billed by the facility then after annual deductible, 100% of covered charges for services billed by the facility and 90% of other covered charges. For confinement past mother's stay and new admissions to hospital.	**Pre-certification Required for newborn hospital stay longer than mother.** 70% of covered charges after annual deductible. For confinement past mother's stay and new admissions to hospital.

Pre-Natal and Post-Natal Care	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of other covered charges. As often as determined appropriate by doctor.	70% of covered charges after annual deductible.
Tubal Ligation	Hospitalization co-pay (inpatient or outpatient) for services billed by the hospital then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of covered charges for services billed separately including physician services.	70% of covered charges after annual deductible.
Vasectomy	Hospitalization co-pay (inpatient or outpatient) for services billed by the hospital then after annual deductible, 100% of covered charges for services billed by the hospital and 90% of covered charges for services billed separately.	70% of covered charges after annual deductible.
TREATMENT OF ILLNESS OR INJURY		
Description	Benefits: In-Network	Benefits: Out-of-Network
Allergy Care	Co-pay (generalist or specialist) if patient sees the physician then after annual deductible, 100% of covered charges for office visit, 90% of other covered charges. 70% of covered charges for serum costs.	70% of covered charges after annual deductible. Includes serum costs and any charges for administering serum.
Diagnostic Testing	After annual deductible, 90% of covered charges. Includes MRI / MRA / CT / PET / SPEC scans.	70% of covered charges after annual deductible. Includes MRI / MRA / CT / PET / SPEC scans.
Laboratory Fees	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.
Surgical Opinion - Second (excludes Best Doctors Program)	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges.	70% of covered charges after annual deductible.

Surgical Opinion - Third (excludes Best Doctors Program)	Specialist co-pay for office visit only then after annual deductible, 100% of covered charges for office visit only and 90% of other covered charges.	70% of covered charges after annual deductible.
Therapy - Radiation Therapy / Chemotherapy	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.
X-Rays	After annual deductible, 90% of covered charges.	70% of covered charges after annual deductible.

Deductibles

You are required to meet a *deductible* when you receive all non-preventive care other than behavioral health accessed through the EAP, dental, and prescription services. The deductible is the amount you pay each plan year for *covered expenses* **before** the Plan pays benefits. The amount of the deductible depends on your coverage status (individual, EE+1, or family). Refer to the Coverage Information chart for specific deductible amounts. Your in-network and out-of-network deductibles are separate and distinct. Eligible in-network expenses apply only to the in-network deductible. Likewise eligible out-of-network expenses apply only to the out-of-network deductible.

If you have EE+1 or family coverage:

- No one individual may contribute more than his or her individual deductible toward the EE+1 or family deductible.
- Until the EE+1 or family deductible is satisfied, claims for each family member are still subject to his or her individual deductible.

Once the EE+1 or family deductible has been satisfied, the deductible for all family members is considered satisfied for the remainder of the plan year. Future covered expenses for all family members during that year will be paid according to the Plan's benefit schedule.

You should submit claims before you have met your deductible.

Note:

- The annual deductible does not apply for preventive care, such as annual physical exams, well baby exams, immunizations, gynecological exams and screenings and routine eye exams.
- Medical co-payments, prescription medication co-insurances, and behavioral health co-payments/co-insurance do **not** count toward the deductible.
- Your in-network deductible **does** count toward your in-network *out-of-pocket maximum* amount.

  Your out-of-network deductible does count toward your out-of-network out-of-pocket maximum amount.

Emergency and Urgent Care Benefits

Your plan will not cover non-emergency use of the emergency room when you could have used area urgent care facilities or your primary physician instead.

Benefits for **emergency** treatment outside the Network service area are limited to coverage for only the emergency care required before you can be safely returned to a Network provider; the deductible applies for in or out-of-network treatment. Benefits for continuation of care and follow up treatment must be provided by in-network providers in order to receive in-network benefits for those services.

Urgent Care

Urgent care services will be covered if services are medically necessary.

Refer to the Coverage Information chart for specific Emergency Care and Urgent Care coverage details.

Hospitalization

The Plan covers *medically necessary* inpatient and outpatient hospital services, including:

- hospital room and board for a semi-private room;
- intensive care and other special unit charges;
- operating and other treatment room charges;
- anesthetics and their administration;
- x-ray and lab services;
- medications and supplies; and
- other hospital services and supplies required for medical or surgical care and treatment.

Benefits depend on whether you receive care *in-network* or *out-of-network*. Benefits are higher if you receive care in-network.

Pre-Certification

The procedure you must follow to obtain pre-certification varies with the type of admission. Failure to obtain pre-certification may result in a substantial benefit reduction, as described in the Procedures > Pre-certification section of this Plan. Therefore it is **strongly recommended** that you follow the necessary pre-certification procedure for each hospitalization, whether it be a scheduled or emergency admission. Refer to the Procedures >Pre-certification section of this Plan for more information on pre-certification. If you are eligible for or a participant in Medicare, also contact Medicare, as pre-certification procedures may be different.

Limitations and Exclusions

The plan does not cover certain types of treatment, services and supplies. In some cases, covered treatment may have limitations, such as annual benefit maximums or frequency limits for certain services or supplies.

Health care benefits coverage in this Plan is not provided to those who reside in a foreign country. Coverage is only provided for emergencies while on temporary travel to foreign countries.

Pre-Existing Conditions

The Plan has **no** limits on treatment of pre-existing conditions.

Reasonable and Customary Charges

If you receive *in-network* covered services, you are **not** responsible for any part of a charge which exceeds the *reasonable and customary* charge for services received. All Network providers have a contract with the Plan which states they will not charge participants more than the allowed charge. **You are responsible for confirming the network membership status of all providers prior to receiving services.** Confirmation should be obtained by contacting your Medical Carrier.

If you are receiving care *out-of-network* and your provider charges you more than the reasonable and customary charge, you are responsible for paying:

- the difference between the reasonable and customary charge and the actual charge; **plus**
- any amounts which are normally your responsibility under the Plan, such as *co-insurance* and deductibles.

As an example of what happens when the fee for a medical service exceeds the reasonable and customary charge, assume:

- medical charges are $650 but the reasonable and customary charge is $600;
- you have already met your *deductible,* but have not yet reached your out-of-pocket maximum; and
- the Plan pays 70%.

The Plan would pay a benefit of $420 (70% times $600). You are responsible for $230, calculated as follows:

- 30% of $600 equals $180, which is your co-insurance amount; plus
- $50, which is the difference between your doctor's charge of $650 and the reasonable and customary charge of $600.

In-network providers offer services at rates that generally do not exceed reasonable and customary charges. Voluntarily utilizing the services of these providers can provide savings in your out-of-pocket expenses. You may access network providers if you live in a local network area. If you are traveling or have children away at school, check with the carrier to determine whether network providers are available in that area.

Any amount which exceeds the reasonable and customary charge will **not** be applied toward your out-of-pocket maximum or deductible.

For details on how a reasonable and customary charge is determined, or to determine if a fee is within the Plan's limits for a reasonable and customary charge, contact the *Medical Carrier*.

Calling your Medical Carrier to determine if a fee is within reasonable and customary limits does **not** eliminate your need to follow the Plan's pre-certification requirements. Failure to obtain the required pre-certification will result in benefit reductions as described in the Procedures > Pre-certification section of this Plan.

Services, Treatments and Supplies Not Covered

The Plan does not cover:

- admission or continued hospital or skilled nursing facility stay for care not medically required on an inpatient basis;
- ambulance service - transportation provided by other than a licensed professional ambulance service;
- aquatic therapy, unless provided under the Treatment of Injury/Illness section of this Plan;
- art therapy, training, supplies or treatments and any related diagnostic testing;
- benefits - any item, service, supply or care not specifically listed as a covered benefit under this Plan;
- biofeedback therapy, training, supplies or treatments and any related diagnostic testing;
- charges for completion of claim forms;
- charges for documentation of medical history;
- charges for failure to keep a scheduled visit;
- charges for holiday, overtime or weekend rates;
- charges for participation in legal proceedings;
- charges for physician or hospital standby services;
- charges for reserving or holding a room or bed that is not being occupied by the member;
- charges not covered because you did not follow Pre-Certification/Authorization procedures;
- chelation therapy except in the treatment of heavy metal poisoning;
- childbirth classes;
- claims filed after claims filing deadline as described in the Procedures > Claims section of this Plan;
- cold therapy devices and combined heat and cold therapy devices designed to combine hot/cold temperatures and compression following injury or surgery to an extremity unless specifically aprroved by the plan.
- communication augmentation devices and related instruction or therapy;
- convenience items - services and supplies for patient convenience such as telephone, television, guest trays and personal hygiene items unless required for a medical condition;
- cosmetic or reconstructive surgery, treatments, and supplies except to restore function of any body area altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes which would normally be covered by the Plan;
- court-ordered - any treatment or therapy which is court ordered, ordered as a condition of parole, probation, or custody or visitation evaluation;
- coverage date - services or supplies provided before the effective date of coverage or after the termination of coverage;
- coverage limits - continued coverage of services when specified limits of coverage have been achieved;
- dance therapy, training, supplies or treatments and any related diagnostic testing;
- dental - any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
- dental - dental implants;
- dental - dentures, appliances, or supplies used in such treatments, unless provided for elsewhere in the Plan;
- dental care, services, supplies or treatment and oral surgery (by physicians or dentists) including dental surgery or other dental procedures. Exceptions: oral surgery to correct congenital defects that prohibit normal function for a covered child; the treatment of temporomandibular joint syndrome (TMJ) or myofacial pain (coverage is limited to removable appliances for TMJ repositioning, related diagnostic services and necessary surgical intervention for correction of TMJ); treatment of traumatic accidental injury, other than one associated with chewing;
- diagnostic services performed in the absence of definite symptoms of an illness;
- duplicate testing not deemed necessary for diagnosis or treatment;
- durable medical equipment items for comfort or convenience;

- eating disorders - services for inpatient treatment of bulimia, anorexia or other eating disorders that consist primarily of behavior modifications, diet and weight monitoring and educational services. This exclusion applies unless prior approval has been obtained for treatment of conditions that are life threatening;
- educational therapy, training, supplies or treatments and any related diagnostic testing;
- educational/developmental services or supplies, including those supplies deemed educational/developmental;
- elastic stockings and bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription;
- environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers or vacuum devices;
- experimental, investigational or unproven care, treatment, medications which are experimental or investigational in terms of generally accepted medical standards;
- fitness - general fitness programs, exercise programs, exercise equipment and health club memberships;
- foot care - services for routine foot care or the treatment of flat feet, corns, bunions, calluses, toenails, fallen arches, weak feet or a chronic foot strain, unless the treatment is an approved surgical or medical procedure;
- foreign country medical services - non-emergency services rendered outside of the United States or U.S. sovereign territories. Coverage is provided for covered members who experience emergency illness or injury while on temporary travel to foreign countries;
- gender modification - surgical or medical treatment to identify or modify the gender of an individual or directly related to gender modification or identification;
- genetic counseling and genetic testing and/or care that is directly related to genetic testing that has not been approved by the plan;
- government plans - services, supplies, treatments, or medications eligible for submission for coverage by Workers' Compensation, Medicare, or similar government plans, whether or not coverage was elected or a claim for coverage was submitted;
- habilitative services;
- hair transplants, hair weaving, hair pieces, wigs, wig maintenance, cranial prosthesis, medications or other services, related to or for inadequate hair growth or loss of hair unless otherwise stated by the Plan;
- hearing aids or examination for fitting;
- hearing tests except when medically indicated to rule out suspected hearing disorder;
- holistic or homeopathic - treatment, services or supplies for holistic or homeopathic medication or other programs that are not accepted medical practices, as determined by the Plan;
- home health-care services which are not medically necessary or of a non-skilled level of care;
- home services - food, housing, homemaker services, sitters, home-delivered meals;
- hospitalization or confinement in a health facility primarily for rest, custodial, maintenance or domiciliary care; or to control or change environment, such as confinement in an eating disorder unit;
- hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;
- in-home birth - services, supplies or care provided during in-home births. Exception - emergency response care;
- infant formula with or without prescription;
- infertility - donor semen or eggs;
- infertility - services for dependent children or household dependents;
- infertility - treatment of infertility following voluntary sterilization;
- infertility treatment coverage over $2,500 per plan year per subscriber membership (family) for medical expenses;
- inpatient - exams or tests done as inpatient for convenience when such care could be provided in an outpatient facility;
- inpatient hospitalization and related services or care rendered primarily for diagnostic studies or observation;

- inpatient or outpatient care, when the participant is medically stable and does not require skilled nursing care or the constant availability of a physician, or the treatment is primarily for congenital or neurological learning disorder, maintaining the current level of health (habilitative), communication training, educational training, vocational training, or the patient has no restorative potential;
- legal - medications or care received in violation of the law;
- maintenance or custodial care, rest cures or travel expenses even if recommended for health reasons by a physician. Transportation to another area for medical care is also excluded except when medically necessary and authorized for you to be moved by professional ambulance service from one hospital to another;
- maintenance or custodial care; care which is provided to maintain an individual at the current level of functioning or primarily to assist with activities of daily living;
- male gynecomastia - cost associated with male gynecomastia;
- massage therapy, unless provided under the Physical Therapy provision of this Plan;
- maxillary or mandibular implants unless for restoration of function following trauma or dysfunction due to medical disorder;
- medical necessity - care, supplies or equipment not medically necessary for the treatment of injury or illness including, but not limited to employment, camp, sports, insurance or aviation physicals and other third party exams; Care must be consistent with the symptom or treatment of the condition; meet the standard of practice; not be solely for anyone's convenience; be the most appropriate supply or level of care safely provided. For inpatient care, it means care cannot be safely provided as an outpatient;
- medications - legend - prescription medications prescribed by a licensed physician and dispensed by a physician or pharmacist as a legend medication (prescription benefits may apply);
- medications - prescription medications normally covered under a prescription medication program (whether or not the medical benefits carrier provides your prescription medication coverage);
- medications other than those administered while in the hospital or physician's office, unless benefits are provided elsewhere in this Plan;
- medications which do not require a prescription;
- military service or act of war - treatment of illness and injury caused by any military service or act of war, declared or undeclared between governments or government-like entities and not simply by a group prone to violence;
- modifications to your home or property, such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts or ramps;
- motor vehicle purchase, rental or conversion to accommodate a disability;
- multiple Plan provisions - covered expenses (services, supplies, equipment, facilities, etc.) will be paid under only one provision of the Plan;
- music therapy, training, supplies or treatments, and any related diagnostic testing;
- non-covered expenses - expenses for services, treatments, supplies, or medications that have been determined as non-covered through Pre-Certification/Authorization, concurrent or retrospective review, and/or appeal review;
- nutritional supplements except in situations where supplements are the only source of nutrition for an individual, the condition was caused by medical disease or injury, and authorization is obtained;
- obesity - treatment for obesity;
- organ transplants - costs for or in connection with a transplant when the patient or provider has not followed Pre-Certification requirements or the patient or provider has been notified by the plan that the organ transplant will not be covered by the plan. Includes all services, treatments or supplies related to pre-transplant evaluation, the transplant procedure, follow-up care, and pre and post transplant prescription medications;
- organ transplants - government-sponsored services, such as Medicare's program for kidney transplants, for which benefits would have been paid if they had been applied for on a timely basis;
- organ transplants - pre and post-transplant prescription medications - covered under the prescription medication benefits;
- organ transplants - services related to donation of organs or tissues if the recipient of the donation has donor expense coverage;

- organ transplants - surgical or medical care related to animal organ transplants, animal tissue transplants, artificial organ transplants or mechanical organ transplants;
- organ transplants - transplants of organs, tissues or bone marrow other than those approved prior to transplantation;
- organ transplants - travel time and related expenses of an organ donor;
- other Company plans - expenses which are covered by another Plan to which the Company contributes;
- payment - care for which you have no legal obligation to pay;
- payment - charges for services or supplies when another Plan, person or third party has the obligation to provide funds for payment;
- payment - excessive Plan payments due to a provider waiving a portion of his/her typical charges. If a provider routinely waives (does not require you to pay) a co-payment, deductible, or coinsurance, the claims administrator will calculate the eligible charges by reducing the fee or charge by the amount waived;
- payment - services or supplies for which funds which could be used for payment of medical expenses were received in a legal action or settlement;
- payment - services or supplies for which you would not be obligated to pay in the absence of this Plan or which are provided to you, or your dependent, at no cost;
- payment - services paid under Medicare, any local, state, or federal government, or Worker's Compensation or which would have been paid if the member had applied for benefits;
- penile implant devices and surgery, and any related services, except for any resulting complications and medically necessary services as provided under reconstructive surgery benefits;
- physician care - any services for any period during which the participant is not under the continuing care of a physician;
- physician licensure - services or supplies that are not performed by or prescribed by a physician licensed to practice medicine, except where otherwise specified;
- private duty care - services or supplies in connection with private duty care, except when licensed nursing care is authorized as medically necessary and the care is provided under the Home Health Care, Home Hospice Care, Facility Hospice Care and Organ Transplants benefits;
- providers - services of a provider who ordinarily resides in the patient's home or is a member of the family of either the patient or the patient's spouse;
- reading therapy, training, supplies or treatments and any related diagnostic testing;
- reasonable, usual and customary charges - expenses in excess of the reasonable, usual and customary charges (as determined by the Claims Administrator);
- recreational therapy, training, supplies or treatments, and any related diagnostic testing;
- residency - services, treatments or supplies for employees or retirees and dependents residing outside of the United States or U.S. sovereign territories;
- routine exams and tests except as provided for under the Preventive Care section of this Plan;
- self-care or self-help training, supplies or treatments, and any related diagnostic testing;
- sex therapy;
- sexual dysfunction - treatment for impotency, loss of libido, or other sexual dysfunctions or inadequacies;
- smoking deterrents or other services or supplies used to treat dependency on nicotine;
- sterilization reversal - services or supplies related to or for reversal of previous sterilization procedures;
- vision - purchase or fitting of eye glasses or contact lenses, unless provided elsewhere in the Plan;
- vision - radial keratotomy or other surgery, services or supplies for the correction of visual defects or for vision improvements;
- vision - vision therapy or orthoptics (eye exercises), unless provided elsewhere in the Plan;
- vocational or industrial rehabilitation;
- vocational therapy, training, supplies or treatments or any related diagnostic testing;
- weight control programs, therapy, training, supplies or treatments and any related diagnostic testing;
- weight reduction or dietary control - any services or supplies used to assist in weight reduction or dietary control, includes bariatric surgery;

- work-connected injuries or diseases – services, supplies, treatments or medications for or in association with injuries or diseases which have been medically determined as occupationally acquired.

Maximums

The Plan has annual dollar and frequency maximums on certain services. The Plan also has an annual *out-of-pocket maximum* that limits the amount you pay for *covered expenses* during the plan year.

Out-of-Pocket Maximums

Your in-network and out-of-network out-of-pocket maximums are separate and distinct. Eligible in-network expenses apply only to the in-network out-of-pocket maximum. Likewise, eligible out-of-network expenses apply only to the out-of-network out-of-pocket maximum.

Once you reach, or a dependent reaches the individual out-of-pocket maximum, the Plan will pay 100% of most of the eligible, covered expenses for that individual for the rest of the plan year. Once you reach the EE+1, EE+1/Family, or Family out-of-pocket maximum (as applicable at your site), the Plan will pay 100% of most of the eligible, covered expenses for you and your covered family members for the rest of the plan year.

Not all of your out-of-pocket expenses are applied to the out-of-pocket maximum. In addition to the items listed on your Plan's Coverage Information chart, premiums paid for health care coverage, charges above eligible amounts and penalties for not obtaining *pre-certification* are **excluded** from the out-of-pocket maximum. Further, any expenses the plan would not normally pay will continue to be your responsibility even after the out-of-pocket maximum has been reached.

Note: After the annual out-of-pocket maximum is reached, you will still be required to pay co-insurance each time you fill a prescription at a participating pharmacy. Prescription co-insurance is **not** credited toward the annual out-of-pocket maximum.

The maximums are listed in your Coverage Information chart.

Preventive Care Guidelines

Medical check-ups and preventive tests and procedures are an important element of maintaining one's health and treating medical conditions in a timely manner. The age appropriate timing of these procedures is based on the recommendations of the U.S. Preventive Services Task Force Guide to Clinical Preventive Services (http://www.ahrq.gov/clinic/cps3dix.htm) and "Preventing Cancer, Cardiovascular Disease, and Diabetes: A Common Agenda for the American Cancer Society, the American Diabetes Society, and the American Heart Association" (http://caonline.amcancersoc.org/cgi/content/full/54/4/190).

Screening Guidelines:

- **Blood pressure measurement and Body Mass Index (BMI)** calculation from measured height and weight, after age 18 years, with each regular health care visit or at least every 2 years if BP < 120/80 mmHg. More frequent BP monitoring is indicated if BP is found to be 130/85 mmHg or higher. **Covered at 100%** as part of a routine preventive care physical.**
- **Blood lipid profile**, including Total Cholesterol, LDL-Cholesterol, HDL-Cholesterol, and Triglyceride levels, after age 20 years, every 5 years. Covered at 100%**, no age limitation
- **Fasting blood glucose**, after age 45 years, every 3 years. Covered at 100%**, no age limitation
- **Clinical breast exam**, after age 20 years, every 3 years, then clinical breast exam and mammography, after age 40 years, every 1-3 years. Mammography covered at 100%** annually after age 40

- **Pap smear**, after age 20 years, yearly, and then after age 30 years, every 1-3 years. Annual Pap Smear covered at 100%** no age limitation.
- **Chlamydia trachomatis screening** for all sexually-active women aged 25 years and younger. Annual Chlamydia screening covered at 100%** age 25 and younger.
- **Colorectal cancer screening**, after age 50 years, utilizing one of the following options:
  - Annual fecal occult blood test or fecal immunochemical test. Covered at 100%**
  - Flexible sigmoidoscopy every 5 years, covered at 100%** once every 5 years
  - Double contrast barium enema every 5 years, covered at 100%** once every 5 years
  - Colonoscopy every 10 years, covered at 100%** once every 10 years
- **Osteoporosis screening** of all women at age 60 years, with follow-up screening as recommended by their clinicians. Osteoporosis screening via DXA scan covered at 100%** for women age 60 and over

Exceptions to these recommended guidelines, as prescribed and scheduled by a treating physician because of family and/or individual medical history, would be covered.

Additional preventive care services currently covered at 100% can be found under Benefit Amount (What's covered) > Coverage information > Preventive Care within this Plan.

**100% coverage applies to employee co-insurance for services obtained in-network. 100% coverage does not apply to office visit co-payment. Out-of-network preventive care services are covered at regular out-of-network co-insurance level. Out-of-network deductible does not apply.

Other Plan Details

P&G provides a network of generalists and specialists to handle your medical needs. In addition, special programs for transplants and care management are available if you should need them.

Under this Plan, **each time** you need medical care, you have a choice of using physicians, hospitals and labs either *in-network* or *out-of-network.* Benefits are higher for care received in-network.

Certain services require *pre-certification* before benefits will be provided. There are also certain limitations and exclusions on benefits.

Once you enroll in one of the P&G Medical Plans, you will receive plan ID cards usually within 30 - 45 days of the date of the enrollment. These cards should be presented whenever you receive medical services. Usually a separate prescription card will be issued. Present your prescription card whenever you receive prescription services. If you need additional plan ID cards, contact the carrier.

If a new Plan is offered and you do not enroll, your failure to actively enroll within the allotted time periods is considered as a waiver of coverage.

Network Information

This plan gives you access to a network of health care providers, including hospitals and physicians, who have agreed to provide medical treatment and preferred fees that assures high quality, cost-effective care.

Under the Plan, you always have the choice of receiving either *in-network* or *out-of-network* care. This means that **each time** you receive care you have the right to decide who will render your treatment: network providers or non-network providers.

Network providers have a contractual arrangement with your Medical Carrier. This arrangement requires that they receive no more than an allowed charge. It also requires them to accept direct payment from the Plan. Therefore, some in-network services are rendered without cost to you, while others require *co-insurance*, a *co-payment*, or a *deductible* be paid at the time care is received. Some in-network benefits are subject to an annual deductible. Some in-network benefits may also be subject to *pre-certification* requirements.

Network membership can periodically change and you are responsible for confirming that a provider is a network member prior to receiving services. Confirmation should be obtained by contacting the carrier.

At any time, you may choose to receive "out-of-network" care. This means your care is rendered by non-network providers. Benefits are lower, and your out-of-pocket costs are higher for out-of-network care. Most out-of-network benefits are subject to a deductible, as well as to the Plan's *reasonable and customary* charge limits. Some out-of-network benefits may also be subject to pre-certification requirements.

When you enroll in this plan, you and any covered family members are **not** required to choose a Primary Care Physician to coordinate your care. However, the Plan encourages you to establish a relationship with a physician to coordinate your treatment and help ensure overall quality of care.

Referrals

You are **not** required to have a referral to a network specialist provider when you need specialized care. However, it is still important that you consult with a primary physician regarding your need for specialty care and to coordinate your care.

IMPORTANT: When seeking specialty care, you must choose a specialist within the network to receive *in-network* benefits. If you are referred to a specialist by your primary physician, it is your responsibility to determine if the specialist is in the network. In-network providers are **not** required to refer members only to other network providers. If you are in doubt as to whether a specialist is in the network, contact the carrier.

If you choose to see an *out-of-network* provider, benefits for services of that provider will be paid at the out-of-network level.

Your primary physician or specialist must provide a prescription or medical order for some services to be covered under the Plan. Examples of these include lab work and physical therapy. Further, the Plan requires prior *pre-certification* for full in-network or out-of-network coverage of some specialized services, such as inpatient hospitalization and transplants.

If you are in doubt as to whether a referral, medical order, prescription or carrier pre-certification is required, it is your responsibility to contact the carrier to determine the requirements **before** receiving services.

Women's Health and Cancer Rights Act of 1998 Provisions

The Women's Health and Cancer Rights Act of 1998 is United States federal legislation that sets coverage requirements for reconstructive breast surgery and related surgical procedures, as well as prostheses. The P&G health care plans comply with this legislation through coverage of the following:

- coverage for reconstruction of the breast on which a mastectomy has been performed;
- coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance;
- coverage for prostheses and physical complications through all stages of mastectomy, including lymphedema; and
- coverage in a manner that is determined in consultation with the attending physician and patient.

All terms of the plan concerning employee cost share (co-pays, deductibles, co-insurance, etc.) and pre-certification apply to this coverage.

Coordination of Benefits

If you or your dependents are covered by more than one Plan, the payment of benefits is coordinated between the plans. This is called Coordination of Benefits (COB). Specific Plan rules define how benefits are paid and where claims are submitted first.

Prescription benefits may also be coordinated.

The first payer is called the *primary plan* or carrier, and the second payer is called the *secondary plan* or carrier.

Procter & Gamble's Plan will coordinate with benefits that you, or any other covered persons, receive from:

- a government program or programs provided or required by law, including mandatory no-fault automobile insurance (Note: Dental and Vision Plans do not coordinate benefits with Medicare or Medicaid);
- law suits or a settlement agreement resulting from a law suit or potential law suit;
- any group insurance plan or coverage for a group of individuals, including coverage provided under a Health Maintenance Organization or a PPO;
- any coverage provided through a school or other educational institution;
- any individual health policy;
- any individual or group automobile liability insurance, including coverage based on uninsured motorist coverage and/or no-fault coverage.

For purposes of this section, "allowable charges" means any necessary, reasonable and customary charge or item of which is at least partially covered under this Plan, not including any charges that are excluded from coverage under the Plan that may be eligible for coverage under any other plans covering the individual for whom the claim is made. With respect to Medicare "allowable charges" will include only those benefits or items that are covered under this Plan.

Note: Even if your P&G Plan is the secondary Plan, you must follow any required pre-certification/authorization procedures to receive full benefits from the P&G Plan.

Claims may be paid differently if the other plan is an HMO, or if your primary plan pays reduced benefits because you did not comply with provisions of that plan.

If the HMO is the primary plan and your P&G Plan is the secondary plan, the P&G Plan will not provide secondary coverage for services rendered outside the HMO (and therefore not covered by the primary plan).

If you receive reduced benefits because you do not comply with provisions (i.e., pre-certification/authorization, etc.) required by the other plan (not an HMO), the amount of that reduction will not be considered an allowable expense by the P&G Plan.

If an HMO is the secondary plan, how it coordinates benefits with the P&G Plan is specific to the HMO. Check with the HMO to determine how it handles nonduplication of benefits.

By Federal Law, some plans may not be able to coordinate with other coverage. If the P&G Plan will be your secondary coverage, you are required to verify with the plan sponsor of your primary coverage plan that you are eligible to participate in a secondary plan.

Coordination with Medicare

How the Plan coordinates its benefits with Medicare depends on whether or not you are *actively at work*.

If you are **actively at work** and eligible for Medicare, but have elected to maintain your P&G Medical Plan, you will follow the Plan's normal claim filing procedure. Benefits will be paid by the Plan without considering what Medicare would have paid. Your P&G Plan will remain your primary medical plan.

However, if you are:

- **no longer actively at work**;
- over age 65 and no longer actively working; or
- totally and permanently disabled

and eligible for Medicare, you will submit your claim first to Medicare and then to your P&G Medical Plan along with the Explanation of Medicare Benefits you receive from Medicare.

Benefits from the P&G Medical Plan are coordinated with Medicare benefits as follows:

The Plan will calculate benefits after a claim has been processed by Medicare. P&G's Medical Plan will pay either:

- 100% of the difference between Medicare's payment and the maximum charge allowed by Medicare, or
- the amount the plan would normally pay without Medicare, whichever is less.

If Medicare is primary, please note that even if you do **not** participate in Medicare Part B, the P&G Medical Plan will estimate what Part B **would have paid** in deducting from total covered medical plan expenses.

The P&G Medical Plan considers eligible charges to be the amount approved by Medicare. Charges beyond the eligible amount are not reimbursable. However, if a benefit is **not** covered by Medicare but **is** an eligible benefit under the P&G medical plan, the service will be covered by the P&G medical plan at the appropriate benefit level.

Eligibility Due to Age

As long as you are an active employee, your coverage through the P&G Medical Plan will continue to cover you and your dependents as your *primary plan*.

You may enroll in Medicare, which becomes the *secondary plan*, or you can wait to enroll in Medicare when you are no longer an active employee.

If you enroll in Medicare, you may file a claim with Medicare for any charges or parts of charges not covered under your plan.

Eligibility Due to Disability

If you are disabled and not *actively at work* due to long-term disability, Medicare will become your *primary plan*. In most cases you will be automatically enrolled in Part A (inpatient hospital services) 24 months after receiving Social Security Disability benefits. You will also be offered enrollment in Part B. The P&G Medical Plan assumes you are enrolled in both Medicare A and B when calculating (coordinating) benefits, so you should enroll to maintain full levels of coverage.

Your P&G Medical Plan will be your *secondary plan* as long as you are covered under that Plan. As the secondary plan, benefits are coordinated with Medicare's payment policy.

Reimbursements for Medicare Part B Premiums

- If Medicare is your *primary* coverage because of long-term disability, and you have more than 10 years of service at the time you reach 105 weeks of disability, your P&G Medical Plan will provide monthly payments to reimburse you for Medicare Part B premiums. The payments will include a gross-up amount to you to pay for additional taxes resulting from this payment. The gross-up will help ensure the payments fully reimburse you for Part B premiums after taxes.
- If Medicare is your primary coverage because of long-term disability, and you have less than 10 years of service at the time you reach 105 weeks of disability and you are required to pay the full cost of your health care benefits, the premium for your P&G Medical Plan will be reduced to reimburse you for your Medicare Part B premium.

Eligibility Due to End Stage Renal Disease

If you or anyone covered by the Plan, regardless of age, receive kidney dialysis treatments and/or a kidney transplant as a result of end stage renal disease, you may qualify for Medicare. Medicare protection usually begins the third month that dialysis begins, or the month of admission for a kidney transplant.

There are two ways your Medicare protection can begin earlier:

- Medicare coverage can begin in the first month of dialysis if:
  - you participate in a self-dialysis training program in a Medicare-approved training facility;
  - you start the training before the third month after dialysis begins; and
  - you expect to complete the training and self-dialyze after that.
- Medicare coverage can begin the month you are admitted to an approved hospital for a kidney transplant or procedures preliminary to a transplant if:
  - the transplant takes place in that month or within the two following months.*

  *If your transplant is delayed more than two months after you are admitted to the hospital for the transplant or procedures preliminary to the transplant, Medicare will begin two months before the month of the transplant.

In most cases, Medicare becomes your *primary plan* after the first 30 months of dialysis, regardless of when you enrolled in Medicare.

Once Medicare is primary, any charges or parts of charges not covered under Medicare may be submitted to the P&G Medical Plan as the *secondary plan*. When the Company's plan is secondary, benefits are coordinated with Medicare's payment policy.

Spouse of an Active Employee

If your spouse becomes eligible for Medicare due to his or her age or disability, and you are an active Procter & Gamble employee, your P&G Medical Plan will continue to be your covered spouse's *primary plan*.

Your spouse may enroll in Medicare, which becomes the *secondary plan*, or he or she can wait to enroll in Medicare when you are no longer an active employee.

If your spouse enrolls in Medicare, he or she may file a claim with Medicare for any charges or parts of charges not covered under the P&G Medical Plan.

Coordination with Other Coverage

Conditional Payments

If you or a covered family member becomes eligible for benefits under the Plan as a result of an injury for which expenses are paid or payable by a third party, P&G may make advance expense reimbursements to, or payment on behalf of, you or a covered family member pursuant to this Plan. Such reimbursements or payments shall be subject to the Plan's reimbursement and/or subrogation rights. However, before any such reimbursements or payments will be conditionally made, P&G may require that you or a covered family member execute an agreement that acknowledges and affirms (1) the conditional nature of the reimbursements or payments; and (2) the Plan's rights of reimbursement and/or subrogation.

Reimbursement

Any benefits under the Plan paid to a you or a covered family member shall be treated as an advance expense reimbursement for any such expenses which are paid by or are payable by a third party, including, but not limited to, an award of insurance benefits, such as benefits provided by the Social Security Administration (SSA).

You agree or your covered family member agrees to identify potential sources of benefits or recoveries to the Plan, to apply for and notify the Plan when he or she applies for insurance benefits or any other benefits which may be available to them from a third party, and to notify the P&G Plan when he or she receives an award of benefits or recovery as a condition to receiving any advance payments from the Plan.

Any such benefits which are awarded retroactively shall be treated as having been received by you or your covered family member during the entire period for which such benefits are payable and any overpayments of advance payments shall be repaid to the Plan within thirty (30) days of receiving such benefits or recoveries. If you or your covered family member does not repay such overpayments made by the Plan, then the Plan may suspend or reduce Plan benefits until the total amount suspended equals the total amount of the overpayment.

Subrogation

Any expenses that are paid or that are payable by third parties are excluded from coverage under the Plan. If you or your covered family member receives any benefits arising from an injury or illness for which you or a covered family member have, may have, or assert or may assert any claim or right to recovery against a third party or parties, then any advance payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan is temporarily assisting the Participant until the third party pays such expenses and that the Plan will be reimbursed for such payment(s). Such reimbursement will be made by you or a covered family member to the extent of, but not exceeding, the total amount payable to or on behalf of you or your covered family member from: (1) any policy or contract from any insurance company or carrier (including your insurer or your covered family member's insurer); and/or (2) any third party, plan, or fund as a result of a judgment or settlement; and/or (3) any third party that may award such benefits, including SSA disability or old age benefits. You acknowledge and agree that this Plan will be reimbursed in full, from any partial or full recovery payable to or on behalf of you or a covered family member before any amounts (including attorney fees incurred by you or a covered family member) are deducted from the policy, proceeds, award of benefits, judgment, or settlement. You agree and agree on behalf of your covered family member to recognize the Plan's right of subrogation and reimbursement. Your or your covered family member's right to be made whole is superseded by the Plan's subrogation rights. These rights provide the Plan with a priority over any partial or full recovery paid by a third party or insurer to you or a covered family member relative to the injury or illness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

This Plan will be subrogated to all claims, demands, actions, and rights of recovery against any entity, including, but not limited to, third parties and insurance companies and carriers (including your insurer or your covered family member's insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under this Plan arising out of the injury or illness for which you or a covered family member has, may have, or asserts a cause of action. In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights. You or your covered family members are responsible for all attorney's fees and court costs. The Plan will not reimburse you or a covered family member for any portion of these expenses. You agree and agree on behalf of your covered family member to do nothing to prejudice this Plan's right to reimbursement or subrogation. In addition, you agree and agree on behalf of your covered family member to cooperate fully with P&G in asserting and protecting the Plan's subrogation rights. You agree and agree on behalf of your covered family member to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect this Plan's subrogation rights, including, but not limited to, holding any proceeds in trust for the benefit of the Plan; distributing the proceeds to the Plan upon demand by the Plan; and refraining from making any distribution of any settlement proceeds until the Plan approves the settlement.

You agree and agree on behalf of your covered family member, to notify the P&G Plan, in writing, of whatever benefits are paid under this Plan that arise out of injury or illness that provides or may provide the Plan subrogation rights.

Failure to comply with these requirements by you or your covered family member(s)may, at P&G's discretion, result in reduction, suspension or forfeiture of benefits under this Plan.

Coordination of Coverage When P&G is the Secondary Plan

When P&G's Plan is the *secondary plan*, it will pay only benefits for allowed expenses if its benefits exceed the payment from the *primary plan*. Note that claims should **always** be filed with the primary plan first.

Payment works as follows:

- the Plan determines the amount it would pay on a claim if it were primary; then
- if there is a difference between the amount payable by the primary plan and the amount that the Plan would have paid as a primary plan, P&G's plan will pay the difference.

When benefits are paid from two sources, the total benefits received from Procter & Gamble and the other insurer may not exceed the allowable charges. The primary plan will pay benefits first for the allowable charges you incur. The secondary plan, P&G, will pay benefits for any remaining eligible charges. Benefits paid from both plans will never exceed what the P&G Plan would have paid had it been the only coverage. This COB process is considered a normal or non-duplication method of Coordination of Benefits determination.

Members who have another carrier for primary prescription benefits may request to have their claims coordinated between their primary plan and the P&G prescription plan. To request coordination of prescription benefits, submit a copy of the pharmacy payment receipt and a copy of the Explanation of Benefits (EOB) or other documentation of payment from the primary carrier (if provided) to your *Prescription Plan Carrier*. The claim will be reviewed to determine if any secondary benefit will be paid under the P&G plan.

Please note: If your Prescription Plan Carrier is Caremark, for secondary coverage, Caremark will determine amount of the prescription cost that has not been paid by the Primary Plan, and will determine coverage of the unpaid amount by applying P&G's standard Prescription coverage co-insurance, rather than using the standard non-duplication method of Coordination of Benefits. Also, Caremark will not refer to this coverage process as Coordination of Benefits, but will process the secondary payment when a claim is submitted using the proper claim form. You can determine your Prescription Carrier by referring to the *Carrier Matrix*.

Rules of coordination for dependents vary with the circumstances.

Note: Even if your P&G Plan is the secondary Plan, you must follow any required pre-certification procedures to receive full benefits from the P&G Plan.

Children of Participant

If your child is covered under your P&G Plan and your spouse's plan, his or her *primary plan* is determined by the birthday rule: your child is covered primarily by the plan of the spouse whose birthday falls earlier in the year.

Note:
If both birthdays are on the same day, the plan which covered the parent longer pays first. However, if one coordinating plan uses the birthday rule and the other uses the male/female rule (father's plan is primary), both plans will follow the male/female rule. This provision avoids the possibility that both plans will be primary or that both plans will be secondary.

If your household dependent (including a domestic partner's child) is covered under your P&G Plan and his or her parent's plan, his or her parent's plan is primary.

Submit the claim first to whichever plan is primary. Then, file a claim with the other plan, along with a copy of the primary plan's *Explanation of Benefits* and a copy of the itemized bill.

Divorce Decree/Joint Custody

If there is a divorce decree or joint custody decree which specifies responsibility, the primary plan is the plan of the parent who is responsible for coverage according to the decree.

If there is no decree that specifies responsibility:

- the plan of the parent with custody pays first;
- the plan of the spouse of the parent with custody (i.e. the step-parent) pays second;
- the plan of the parent without custody pays third; and
- the plan of the spouse of the noncustodial parent pays last.

In all cases, claims are first submitted to the primary plan. Then they are submitted to the secondary plan with the Explanation of Benefits from the primary plan. An individual may not be covered by more than one plan member.

Dependents with Individual Coverage

As an employee of Procter & Gamble, your P&G Plan is your primary plan, and all your claims must be filed with this Plan first. If your dependent (spouse, domestic partner, children or household dependent) is covered under his or her own plan, claims should be submitted to that plan first. When that claim has been processed, you may submit a claim for his or her remaining charges, along with the *Explanation of Benefits (EOB)*, to your P&G Plan.

Any plan without a coordinating provision is always primary. When both plans have coordination provisions:

- The plan covering the person directly as a subscriber is primary. The plan covering the person as a dependent is *secondary*;
- The plan covering the person as an active employee (or as the active employee's dependent) is primary. The plan covering the person as a retired employee (or as the retired employee's dependent) is secondary. If both plans do not have this rule, and if, as a result, the plans do not agree on the order of benefits, previously described rules apply.

Different rules apply if both you and your spouse cover your children or if you are divorced and cover your children.

Note: If none of the rules mentioned in this plan determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

Eligibility

You and your eligible dependent(s) may enroll in the Plan if you are a *full-time* or *part-time* employee (if applicable) and reside in the United States or U.S. sovereign territories.

Specific dependent eligibility requirements are outlined on the applicable dependent page(s) in this Plan.

Eligible dependents may include:

- your spouse (unless legally separated);
- your unmarried children;
- your domestic partner (full-time employees only); and
- your household dependent(s).

No individual may be covered by more than one P&G health care benefits plan.

Spouses and dependent children must reside in the United States or U.S. sovereign territories and be U.S. citizens, permanent residents, or authorized to be in the U.S. for extended periods by way of valid long-term visa. Individuals who are in the U.S. on temporary visas, such as student, tourist, or medical visas, are not eligible for coverage.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

Children

For purposes of eligibility for health care coverage, children include:

- your unmarried children:
  - up to age 19, or up to age 25 if they depend on you for more than one-half of their support; or
  - who are physically or mentally disabled, age 25 or older.

Children means your natural children, stepchildren who live in your household for at least six months of the year, children for whom you have legal guardianship, foster children and legally adopted children. Grandchildren are not covered by the Plan unless legal guardianship has been obtained or they meet the criteria for household dependent.

You may be required to provide documentation of dependent child eligibility. If you are enrolling a dependent child age 19-24 in health care, complete the P&G Dependent Support Test form to confirm the eligibility for these children. Maintain the form in the event of an eligibility audit. It is **not** necessary to send the form to the Employee Service Center.

Disabled Children

A physically or mentally disabled child who has become disabled while an eligible dependent, receives more than one-half his or her support from you and who is incapable of self support, may be eligible as a child dependent past age 24.

Self support includes possible sources of income such as employment earnings, trust funds, payments from insurance companies, investment earnings, etc. You **must** apply for continued eligibility within 30 days of the disabled child's 25th birthday.

You are required to provide proof that the child is and remains disabled and is and remains unable to provide self support. Contact your carrier's customer service to obtain forms to apply for incapacitated dependent status.

Family and Medical Leave Act

For FMLA purposes, child includes a biological, adopted, or foster child, a stepchild, a legal ward, or anyone the employee has raised as a child, who is under 18 years of age or 18 years of age or older and incapable of self-care because of a mental or physical disability, including incapacity for self-care that is due to illegal use of medications.

Spouses and dependent children must reside in the United States or U.S. sovereign territories and be U.S. citizens, permanent residents, or authorized to be in the U.S. for extended periods by way of valid long-term visa. Individuals who are in the U.S. on temporary visas, such as student, tourist, or medical visas, are not eligible for coverage.

Domestic Partner

As a regular *full-time* employee you are eligible for domestic partner benefits if you are covered under Procter & Gamble's U.S. benefit plans. *Part-time* employees are not eligible to enroll a domestic partner in P&G's benefits. Additionally, certain survivor benefits may be available to the surviving domestic partner of eligible employees and retirees.

Procter & Gamble defines same or opposite sex domestic partners as two people in a spouse-like relationship who have met all of the following requirements for at least the last twelve (12) months:

- intend to remain each other's domestic partner indefinitely;
- reside together in the same permanent residence;
- neither of you are legally married or separated nor the domestic partner of anyone else;
- neither of you is related by blood to a degree of kinship that would prevent marriage under applicable law of the state where you reside;
- both are jointly responsible for each other's welfare and financial obligations, or, your domestic partner is chiefly dependent upon you for care and financial assistance; and
- both are at least eighteen (18) and are mentally competent to enter into a legal contract.

A roommate **can not** be a domestic partner.

Federal regulations define the eligibility of domestic partners in certain plans and require P&G to treat domestic partners differently than spouses. As a result of these differences, domestic partners are treated one of two ways:

- ***domestic partner - a legal tax dependent***
- ***domestic partner - not a legal tax dependent***

To be considered an eligible domestic partner, P&G must have an accepted *Affidavit of Domestic Partner* on file.

Domestic partners must be U.S. citizens or permanent residents. Individuals who are in the U.S. on long-term or temporary visas, such as work, student, tourist or medical visas, are not eligible for coverage (for purposes of U.S. healthcare eligibility, the individual must also reside in the United States or U.S. sovereign territories). You may be required to show documentation of domestic partner eligibility.

Eligibility Rules

P&G requires that you **establish the eligibility** of your domestic partner by filing the appropriate *Affidavit of Domestic Partner*. Federal regulations limit the filing of an Affidavit to the following enrollment situations:

- *Annual Enrollment* - with eligibility effective at the beginning of the next Plan year. **If you do not file the appropriate Affidavit within the Annual Enrollment period, you will not be permitted to do so until the next Annual Enrollment period**.
- *Special Enrollment Situations* - Within 30 days of situations that provide you with the initial enrollment opportunity (i.e., New Hire), with eligibility effective the date of the event. **If you do not file the appropriate Affidavit within 30 days of the event, you will not be permitted to do so until the next Annual Enrollment period.**

The appropriate Affidavit must be received by the *Employee Service Center* and postmarked by the last day of the eligible enrollment period to ensure eligibility.

Even if you currently do not want to enroll your domestic partner in health care or FlexComp benefits, you must have a signed Affidavit on file if you wish your domestic partner to be eligible for other P&G Plans and benefits or eligible for health care following specific special enrollment situations.

Enrollment Rules

To enroll your domestic partner you must **establish the person's eligibility by filing the appropriate Affidavit AND complete the benefit enrollment process.** Federal regulations limit your opportunity to enroll domestic partners in most benefits to the following enrollment situations:

- Annual Enrollment - with coverage effective at the beginning of the next Plan year. **If you do not enroll during the Annual Enrollment period, you will not be permitted to do so until the next Annual Enrollment period**.
- Special Enrollment Situations
  - Initial Enrollment Situations (i.e., New Hire, etc.) - within 30 days of certain situations that provide you with an initial enrollment opportunity, with coverage effective the date of the event. **If you do not file the appropriate Affidavit within 30 days of the event, you will not be permitted to do so until the next Annual Enrollment period.**
  - Gain or Loss of Health Care Coverage or Job - within 30 days of the gain or loss of health care coverage or job, **as long as an Affidavit is already on file**.

Eligibility for all domestic partners is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a domestic partner who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30** days of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a domestic partner - legal tax dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

Some states have common law marriage statutes that may give legal spouse status to some opposite-sex domestic partners. If married by common law, you have a "spouse" rather than a domestic partner so you can enroll him or her through the regular enrollment process.

Note: You are urged to seek appropriate advice before signing an Affidavit of Domestic Partnership for purposes of enrollment in benefit coverage provided for employees of the Procter & Gamble Company or one of its subsidiaries ("P&G") and the employee's eligible dependents. Some courts have recognized non-marriage relationships as the equivalent of marriage for the purpose of establishing and dividing joint property. There may also be other implications to signing the Affidavit of Domestic Partnership document.

Domestic Partner Details- Health Care - Active Employee

Federal regulations define the eligibility of domestic partners in health care plans and require P&G to treat domestic partners differently than spouses. For health care benefits, these differences impact payroll practices as well as eligibility/enrollment rules.

Payroll Practices

Domestic Partner - Not a Legal Tax Dependent

- Premiums you pay for health care benefits must be paid with after-tax dollars if you have a domestic partner who is **not** your legal tax dependent.
- You will be assessed *imputed income* on the value of providing health care benefits (medical, dental, etc.) to a domestic partner who is **not** your legal tax dependent.

All Domestic Partners

- Federal regulations require that *imputed income* be assessed if you remove a domestic partner from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year.

For more information, refer to the Taxes section of the Plan.

Eligibility Rules - Refer to the Eligibility > Domestic Partner section of the Plan for domestic partner eligibility details.

Enrollment Rules - Refer to the Procedures > Enrollment > Additional Enrollment Information - Domestic Partner and/or Household Dependent section of the Plan for domestic partner enrollment details.

Eligibility for all domestic partners is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a domestic partner who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30** days of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a domestic partner - legal tax dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year.

Children of your Domestic Partner

You may also enroll the child(ren) of your domestic partner in health care benefits if they qualify as your *household dependent(s)*.

No individual may be covered by more than one P&G health care benefits plan.

Household Dependents

To qualify as a household dependent, an individual must meet **all** of the following requirements:

- be under age 65;
- be a U.S. citizen or permanent resident. Individuals who are in the U.S. on long-term or temporary visas, such as work, student, tourist, or medical visas, are not eligible for coverage (for purposes of U.S. healthcare eligibility, the individual must also reside in the United States or U.S. sovereign territories);
- receive more than one-half of his or her support from you for the calendar year;
- live in your household for the entire calendar year (except for temporary absences due to illness, education, business, vacations, military service or an indefinite stay in a nursing home).

Your housekeeper, maid, servant or other domestic employee who lives with you **can never** be your household dependent.

You may be required to show documentation of household dependent eligibility.

Eligibility Rules

P&G requires that you **establish the eligibility** of your household dependent(s) by filing the appropriate *Affidavit of Household Dependent*. Federal regulations limit the filing of an Affidavit to the following enrollment situations:

- *Annual Enrollment* - with eligibility effective at the beginning of the next Plan year. **If you do not file the appropriate Affidavit within the Annual Enrollment period, you will not be permitted to do so until the next Annual Enrollment period**.
- *Special Enrollment Situations* - Within 30 days of situations that provide you with the initial enrollment opportunity (i.e., New Hire), with eligibility effective the date of the event. **If you do not file the appropriate Affidavit within 30 days of the event, you will not be permitted to do so until the next Annual Enrollment period.**

The appropriate Affidavit must be received by the *Employee Service Center* and postmarked by the last day of the eligible enrollment period to ensure eligibility.

Even if you currently do not want to enroll your household dependent(s) in health care or FlexComp benefits, you must have a signed Affidavit on file if you wish your household dependent(s) to be eligible for other P&G Plans and benefits or eligible for health care following specific special enrollment situations.

Enrollment Rules

To enroll your household dependent(s) you must **establish the person's eligibility by filing the appropriate Affidavit AND complete the benefit enrollment process.** Federal regulations limit your opportunity to enroll household dependent(s) in most benefits to the following enrollment situations:

- Annual Enrollment - with coverage effective at the beginning of the next Plan year. **If you do not enroll during the Annual Enrollment period, you will not be permitted to do so until the next Annual Enrollment period**.

- Special Enrollment Situations
  - Initial Enrollment Situations (i.e., New Hire, etc.) - within 30 days of certain situations that provide you with an initial enrollment opportunity, with coverage effective the date of the event. **If you do not file the appropriate Affidavit within 30 days of the event, you will not be permitted to do so until the next Annual Enrollment period.**
  - Gain or Loss of Health Care Coverage or Job - within 30 days of the gain or loss of health care coverage or job, **as long as an Affidavit is already on file**.

Eligibility for all household dependents is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a household dependent who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30 days** of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a household dependent - legal tax dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

P&G Dual Career Domestic Partner Employees

If your domestic partner also works for P&G, you cannot be covered as both an employee and a dependent under health care (medical, dental, etc.) benefits at the same time. This also applies to your domestic partner.

You have two enrollment choices:

- Both you and your domestic partner may enroll in separate plans as employees. If either of you have dependents, you may each carry the appropriate single, EE+1 or family coverage, but you **may not cover each other, or your dependents under each of your respective plans** .
- You may enroll as an employee and cover your domestic partner under EE+1 or family coverage. Whomever is designated as a domestic partner must drop his or her enrollment as an employee.

No individual may be covered by more than one P&G health care benefits plan.

P&G Dual Career Married Employees

If your spouse also works for P&G, you cannot be covered as both an employee and a dependent under health care (medical, dental, etc.) benefits at the same time. This also applies to your spouse.

You have two enrollment choices:

- Both you and your spouse may enroll in separate plans as employees. If either of you have dependents, you may each carry the appropriate single, EE+1 or family coverage, but you **may not cover each other, or your dependents under each of your respective plans**.
- You may enroll as an employee and cover your spouse under EE+1 or family coverage. Whomever is designated as a spouse must drop his or her enrollment as an employee.

No individual may be covered by more than one P&G health care benefits plan.

Spouse

You may enroll your spouse (who is not legally separated) in this Plan. For purposes of eligibility for health care coverage:

Spouse includes a husband or wife as defined or recognized under State law for purposes of marriage in the state where the employee resides, including common law marriage in states where it is recognized.

You may be required to provide documentation of spouse eligibility.

Spouses and dependent children must reside in the United States or U.S. sovereign territories and be U.S. citizens, permanent residents, or authorized to be in the U.S. for extended periods by way of valid long-term visa. Individuals who are in the U.S. on temporary visas, such as student, tourist, or medical visas, are not eligible for coverage.

Special Programs

Procter & Gamble provides two special programs to assist you in obtaining optimal medical care in the most cost effective manner.

- **Medical Care Management** provides assistance for a catastrophic injury or illness for which inpatient hospitalization or a large amount of covered medical expenses are expected to continue over a long period of time. This is also called case management.
- **The Organ Transplant Program** provides a network of nationally recognized facilities that have the experience, training and support services necessary to perform transplantation medicine, including heart, lung, heart/lung, liver, pancreas, pancreas/kidney, kidney, multivisceral and small bowel human organ transplants, as well as any organ not listed but required by law. Cornea transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular Plan benefits and are subject to other applicable provisions of the Plan.

Medical Care Management

If you or anyone covered by the P&G Medical Plan is hospitalized due to a severe injury or illness, you may be eligible to participate in a Care Management Program which is designed to help identify alternatives to a long-term hospital stay.

Under Medical Care Management, health care professionals analyze your case and may suggest possible treatment alternatives that are more advantageous, more convenient and often less expensive. In some cases, recommendations by this program can ensure payment for alternatives that may not be covered otherwise.

All Medical Care Management professionals are highly qualified and have extensive rehabilitation experience. They will evaluate your case and assure that you receive the most appropriate care for your condition. They also work closely with ancillary providers to help you find home nursing care or durable medical equipment.

However, if you prefer, you do not have to accept these recommendations. You, your family and your physician are responsible for making decisions about your health care. Medical Care Management is designed to suggest possible alternatives which you may not have otherwise considered.

Your P&G Medical Plan will identify any situations where this program can be helpful. They will contact your doctor directly to discuss your situation.

Organ Transplant/Bone Marrow Transplant Coverage Information

Procter & Gamble recognizes that solid **organ and bone marrow transplants** are serious medical procedures that require expert providers. We utilize a network of quality facilities located across the United States with clinically renowned transplant programs. The programs were selected based on a number of factors, including successful outcomes, annual case volumes, the transplant team's expertise, the one-year post-transplant survival statistics and geographic location.

If you or a covered family member needs a transplant, your P&G Medical Plan will provide you with information about the appropriate transplant facility. You will select the facility that's best for you.

The types of Organ Transplant services covered include, but are not limited to:

- obtaining and evaluating the donor organ;
- removing the organ from the donor;
- transporting the organ to the site of the transplant operation;
- hospital room and board;
- hospital services;
- doctor's services;
- transportation to and from the nearest transplant center authorized to perform the transplant;
- lodging expenses;
- medical expenses of a living donor associated with providing an organ to a covered member of the Plan.

Post-transplant prescription medications are covered under the Prescription Medication provisions of the Plan, not under the medical coverage.

The Plan covers the costs of heart, lung, heart/lung, liver, pancreas, pancreas/kidney, kidney, multivisceral and small bowel human organ transplants, as well as any organ not listed but required by law. Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular Plan benefits and are subject to other applicable provisions of the Plan. Other transplants may be covered under the Plan in the future if they prove to be successful. Contact the carrier for information concerning possible coverage of other transplants. The Plan also provides benefits for *allogeneic* and *autologous* bone marrow transplants for certain diagnoses.

Bone Marrow Transplants

Allogeneic bone marrow transplants are eligible only when in relation to diagnoses of:

- aplastic anemia;
- acute leukemia;
- severe combined immunodeficiency, e.g., adenosine deaminase deficiency and idiopathic deficiencies;
- Wiskott-Aldrich syndrome;
- infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease);
- non-Hodgkin's lymphoma, intermediate or high grade stage III, or stage IV;
- Hodgkin's disease (lymphoma), stage IIIA or IIIB, or stage IVA or IVB;
- chronic myelogenous leukemia;
- neuroblastoma stage III and IV in children over one year of age;
- homozygous beta-thalassemia (thalassemia major).

Autologous bone marrow transplants are eligible only when in relation to diagnoses of:

- non-Hodgkin's lymphoma, intermediate or high grade stage III, or stage IV;
- Hodgkin's disease (lymphoma), stage IIIA or IIIB, or stage IVA or IVB;
- neuroblastoma stage III and IV;
- acute lymphocytic or nonlymphocytic leukemia following a first or subsequent relapse;
- breast cancer (evaluated on a case by case basis).

As additional diagnoses cease to be *experimental or investigational*, the lists of covered diagnoses may be amended to include such additional diagnoses.

The Plan cannot guarantee that you, or anyone covered by the Plan, will receive a specific organ transplant. There's a limited supply of donors as well as guidelines for determining *medical necessity*, usually set through governmental regulations or conventional medical practice which govern who may receive an organ transplant. Additionally, organ transplant procedures require *pre-certification/authorization*.

If you use *out-of-network* providers for organ transplants, your out-of-network *co-insurance* will not be applied to the annual *out-of-pocket maximum*.

Refer to the Coverage Information chart for specific Organ Transplant coverage details.

Organ Transplant Services Not Covered

Certain services are not included under the Organ Transplant coverage. Please refer to Services, Treatments and Supplies Not Covered and Prescriptions > Prescription Medications Not Covered pages in this plan for specific details.

Prescriptions

Medications which require a physician's written prescription are covered under the Plan.

The Plan pays a percentage of the cost of prescription medications, after an employee co-insurance. The Plan offers coverage for prescription medications purchased at retail pharmacies or through a home delivery program. Prescription medications are classified by the Plan as follows:

Level I Prescription Medications: Level I prescription medications are those which are primarily used to treat pain or preserve or restore body functions that are essential to life.

Level IA Prescription Medications: Level IA prescription medications are those which are primarily used to treat Asthma, Diabetes, Hypertension and High Cholesterol.

The categories of Level IA prescription medications include:

Level IA Condition and Medication Type	Example Medications
Diabetes	
Insulins	Apidra, Humalog, Humalog Mix 50/50, Humalog Mix 75/25, Humulin 50/50, Humulin 70/30, Humulin L, Humulin N, Humulin R, Humulin U, Iletin II Lente (Pork), Iletin II NPH (Pork), Iletin II Regular (Pork) Lantus, Lantus Solostar, Levemir, Novolin 70/30, Novolin 70/30 Innolet, Novolin L, Novolin N, Novolin N Innolet, Novolin R, Novolog, Novolog Flexpen, Novolog Mix 70/30, Relion Novolin 70/30, Relion Novolin N, Relion Novolin R, Velosulin
Oral Hypoglycemics	Acarbose, Acetohexamide, Actoplus Met, Actos, Amaryl, Appformin, Appformin-D, Avandamet, Avandaryl, Avandia, Chlorpropamide, Diabeta, Diabinese, Duetact, Fortamet ER, Glimepiride, Glipizide, Glipizide ER, Glipizide XL, Glipizide-Metformin, Glucophage, Glucophage XR, Glucotrol, Glucotrol XL, Glucovance, Glumetza ER, Glyburide, Glyburide Micronized, Glyburide-Metformin HCL, Glycron, Glynase, Glyset, Janumet, Januvia, Metaglip, Metformin HCL, Metformin HCL ER, Micronase, Nateglinide, Onglyza, Orinase, Prandin, Precose, Riomet, Starlix, Tolazamide, Tolbutamide, Tolinase
Antihyperglycemic, Amylin Analog	Symlin, Symlin Pen
Antihyperglycemic, Incretin Mimetic	Byetta
Asthma	
Anticholinergics, bronchial	Atrovent, Atrovent HFA, Ipratropium Bromide, Spiriva
Anticholinergics Sympathomimetics	Combivent
Anticholinergics/Sympathomimetics Solutions	Duoneb, Ipratropium-Albuterol
Cromolyn Sodium	Cromolyn Sodium, Intal, Tilade
Leukotriene Receptor Antagonists	Accolate, Singulair, Zyflo, Zyflo CR
Corticosteriods, Bronchial	Aerobid, Aerobid-M, Alvesco, Asmanex, Azmacort, Beclovent, Budesonide, Flovent, Flovent Diskus, Flovent HFA, Flovent Rotadisk, Flunisolide, Pulmicort Respule, Pulmicort Turbuhaler, Pulmicort Flexhaler, Qvar, Vanceril, Vanceril Double Strength
Sympathomimetic Inhalers	Albuterol, Albuterol Sulfate HFA, Alupent, Brethaire, Foradil, Maxair Autohaler, Proair HFA, Proventil, Proventil HFA, Relion Ventolin HFA, Serevent, Serevent Diskus, Ventolin, Ventolin HFA,
Sympathomimetic Nebulizers Solutions	Accuneb, Airet, Albuterol Sulfate, Alupent, Bronkosol, Brovana, Isoetharine HCL, Levalbuterol, Metaproterenol Sulfate, Perforomist, Proventil, S-2, Ventolin, Xopenex, Xopenex HFA
Sympathomimetic, Oral Solids and Liquids	Albuterol Sulfate, Albuterol Sulfate ER, Brethine, Metaproterenol Sulfate, Midodrine HCL, Proamatine, Proventil, Terbutaline Sulfate, Ventolin, Volmax, Vospire ER, Broncholate, Kie
Sympathomimetic/Corticosteroid Combinations, Inhalers	Advair Discus, Advair HFA Inhaler, Symbicort
Xanthines	Aerolate, Aerolate JR, Aerolate SR, Aminophylline, Cafcit, Caffine Citrate, Dylix, Elixophyllin, Lufyllin, Lufyllin-400, Pulmophylline, Quibron-T, Quibron-T/SR, Senophyllin, Slo-Bid 100, Slo-Bid 200, Slo-Bid 50, Theo-24, Theo-Dur, Theocap, Theochron, Theophylline, Theophylline Anhydrous, Theophylline ER, Uniphyl
Cholesterol	
Antihyperlidpidemic Agents	Advicor, Altoprev, Antara, Cholestyramine, Cholestyramine Light, Cholestyramine Resin, Colestid, Colestipol HCL, Crestor, Fenofibrate, Fibricor, Gemfibrozil, Lescol, Lescol XL, Lipex, Lipitor, Lipofen, Lofibra, Lopid, Lovastatin, Lovaza, Mevacor, Niacor, Niaspan, Omacor, Pravachol, Pravastatin Sodium, Pravigard PAC, Prevalite, Probucol, Questran, Questran Light, Simcor, Simvastatin, Tricor, Triglide, Trilipi, Welchol, Zocor
Cholesterol Absorption Inhibitors	Zetia
Antihyperlipidemic & CCB Combination	Caduet
Antityperlipidemic & Cholesterol Absorption Inhibitor	Vytorin
High Blood Pressure	
ACE Inhibitors	Accupril, Aceon, Altace, Benazepril HCL, Capoten, Captopril, Enalapril Maleate, Enalaprilat, Fosinopril, Fosinopril Sodium, Lisinopril, Lotensin, Lytensopril, Lytensopril-90, Mavik, Moexipril HCL, Monopril, Perindopril, Prinivil, Quinapril, Quinapril HCL, Ramipril, Trandolapril, Univasc, Vasotec, Zestril
Angiotensin II Receptor Antagonists	Atacand, Avapro, Benicar, Cozaar, Diovan, Micardis, Teveten
Antihypertensives-Misc	Aldomet, Apresoline, Cardura, Cardura XL, Catapres, Catapres-TTS 1, Catapres-TTS 2, Catapres-TTS 3, Clonidine HCL, Demser, Doxazosin Mesylate, Duraclon, Guanabenz Acetate, Guanethidine Monosulfate, Guanfacine HCL, Hydralazine HCL, Hytrin, Intuniv, Inversine, Ismelin, Methyldopa, Methyldopate HCL, Minipress, Minoxidil, Nitropress, Prazosin HCL, Tenex, Terazosin, Terazosin HCL
Reserpine	Reserpine

Antihypertensives Combinations	Enduronyl, Enduronyl Forte, HCTZ/Reserpine/Hydralazine, Uni-serp, Amlodipine Besylate-Benazepril, Lexxel, Lotrel, Tarka, Azor, Exforge, Exforge HCT, Twynsta, Accuretic, Benazepril HCL-HCTZ, Capozide, Captopril/Hydrochlorothiazi, Enalapril Maleate-HCTZ, Fosinopril-Hydrochlorothiazi, Lisinopril-HCTZ, Lotensin HCT, Moexipril-Hydrochlorothiazi, Monopril HCT, Prinzide, Quinapril-Hydrochlorothiazi, Quinaretic, Uniretic, Vaseretic, Zestoretic, Atenolol-Chlorthalidone, Bisprolol Fumarate-HCTZ, Corzide, Inderide 40/25, Inderide 80/25, Lopressor HCT, Metoprolol-Hydrochlorothiazi, Nadolol-Bendroflumethiazide, Propanolol HCL W/HCTZ, Tenoretic 100, Tenoretic 50, Ziac, Atacand HCT, Avalide, Benicar HCT, Diovan HCT, Hyzaar, Micardis HCT, Teveten HCT, Aldoclor-250, Aldoril-D50, Clorpres, Hydra-Zide, Methyldopa-Hydrochlorothiazi, Minizide 1, Minizide 2, Minizide 5, Valturna
Beta Blockers	Acebutolol HCL, Atenolol, Betapace, Betapace AF, Betaxolol HCL, Bisoprolol Fumarate, Bystolic, Carevedilol, Coreg, Coreg CR, Corgard, Hypertensolol, Inderal, Inderal LA, Innopran XL, Kerlone, Labetolol HCL, Levatol, Lopressor, Metoprolol Succinate, Metoprolol Tartrate, Nadolol, Naldol, Normodyne, Pindolol, Propranolol HCL, Propranolol ER, Sectral, Sorine, Sotalol, Sotalol AF, Sotalol HCL, Tenormin, Tenormin I.V., Timolol Maleate, Toprol XL, Trandate, Zebeta
Calcium Channel Blockers	Adalat CC, Afeditab CR, Amlodipine Besylate, Calan, Calan SR, Cardene, Cardene I.V., Cardene SR, Cardizem, Cardizem CD, Cardizem LA, Cardizem SR, Cartia XT, Covera-HS, Dilacor XR, Dilt-CD, Dilt-XR, Diltia XT, Diltiazem CD, Diltiazem ER, Diltiazem HCL, Diltiazem XR, Diltiazem-D5W, Diltzac ER, Dynacirc, Dynacirc CR, Felodipine ER, Isoptin SR, Isradapine, Nicardipine HCL, Nifediac CC, Nifedical XL, Nifedipine, Nifedipine ER, Nimodipine, Nimotop, Norvasc, Plendil, Procardia, Procardia XL, Sular, Taztia XT, Tiazac, Tiazac ER, Verapamil, Verapamil SR, Verelan, Verelan PM,
Diuretics	Chlorothiazide, Chlorthalidone, Diuril, Enduron, Hydrochlorothiazide, Methyclothiazide, Microzide, Naturetin-5, Saluron, Thalitone, Aldactazide, Aldactone, Amiloride HCL, Amiloride HCL-HCTZ, Dyazide, Dyrenium, Eplerenone, Inspra, Maxide, Maxzide-25MG, Midamore, Moduretic, Spironolactone, Spironolactone W/HCTZ, Triamterene W/HCTZ, Bumetanide, Bumex, Demadex, Edecrin, Furosemide, Indapamide, Lasix, Lozol, Metolazone, Torsemide, Zaroxolyn
Renin Antagonists	Tekturna
NOTE: This list is subject to on-going change as medications are developed, changed or become available without a prescription.	

Level II Prescription Medications: Level II prescription medications are those not primarily used to treat pain or preserve or restore life-essential body functions and not primarily used to enhance lifestyle-related activities such as sexual performance, dieting and smoking cessation.

The categories of Level II prescription medications include:

Level II Medication Category	Example Medications
Sedative/Hypnotics (sleep aids)	Ambien, Ambien CR, Ambien PAK, Dalmane, Doral, Estazolam, Flurazepam, Flurazepam HCL, Halcion, Lunesta, Midazolam HCL, Prosom, Restoril, Sonata, Temazepam, Triazolam, Zaleplon, Zolpidem Tartrate, Rozerem
Contraceptives (Birth Control)	Camila, Errin, Jolivette, Micronor, Next Choice 0.75 MG Tablet, Nor-Q-D, Nora-Be, Norethindrone, Ortho Micronor, Ovrette, Plan B, Alesse-28, Apri, Aranelle, Aviane, Azurette 28 Day Tablet, Balziva, Brevicon, Caziant 28 Day Tablet, Cesia, Cryselle, Cyclessa, Demulen 1/35-28, Demulen 1/50-21, Demulen 1/50-28, Desogen, Desogestrel/E.Estradiol Tab, Enpresse, Estrostep FE, Femcon FE, Genora 0.5/35-28 Tablet, Genora 1/35-21 Tablet, Genora 1/35-28 Tablet, Genora 1/50-21 Tablet, Genora 1/50-28 Tablet, Gildess Fe 1.5-30 Tablet, Jenest-28 Tablet, Junel, Junel FE, Kariva, Kelnor 1/35, Leena, Lessina, Levlen 8, Levlite-28, Levora-28, Lo/Ovral-21, Lo/Ovral-28, Lo/Ovral-8, Loestrin, Loestrin 24 FE, Loestrin FE, Low-Ogestrel, Lutera, Lybrel, Microgestin, Microgestin FE, Mircette, Modicon, Mononessa, Necon, Nelova Tab .5/35-28, Nelova 1/35-28 Tablet, Nelova 1/35E-21 Tablet, Nelova 1/35E-28 Tablet, Nelova 1/50M-21 Tablet, Nelova 1/50M-28 Tablet, Nordette-21, Nordette-28, Nordette-8, Norethin Tab 1/35-28, Norgestrel-Ethiny Estra, Norinyl 1, Nortrel, Ocella Tablet, Ogestrel, Ortho Tri-Cyclen, Ortho Tri-Cyclen LO, Ortho-Cept, Ortho-Cyclen, Ortho-Novum, Ovcon FE, Ovcon FE Chewable Tablet, Ovcon 35, Ovcon 50, Ovral-21, Ovral-28, Ovral-4, Portia, Previfem, Reclipsen, Solia, Sprintec, Sronyx, Tilia FE 28, Tri-Legest Fe-28 Day Tablet, Tri-Levlen-28, Tri-Norinyl, Tri-Previfem, Tri-Sprintec, Tri-Lo-Sprintec Tablet, Trinessa, Triphasil-28, Trivora-28, Velivet, Yasmin 28, Yaz, Zenchent, Zovia 1/35E, Zovia 1/50E, Jolessa, Lo Seasonique, Quasense, Seasonale, Seasonique, Nuvaring, Ortho Evra, Depo-Provera, Depo-Subq Provera 104, Implanon, Lunelle, Medroxyprogesterone Acetate
Infertility Agents (if covered by site's plan)	Bravelle, Cetrotide, Chorex-10, Chorionic Gonadotropin, Clomid, Clomiphene Citrate, Crinone, Endometrin Suppository 100MG, First-Progesterone VGS 100, First-Progesterone VGS 200, First-Progesterone VGS 25, First-Progesterone VGS 400, First-Progesterone VGS 50, Follistim AQ, Ganirelix Acetate, Gonal-F, Gonal-F RFF, Luveris, Menopur, Novarel, Ovidrel, Pregnyl, Preception Sperm Nutrient, Prochieve, Profasi, Repronex, Serophene
Acne Treatment Agents	Altinac, Atralin,Avita, Retin-A, Retin-A Micro, Retin-A Micro Pump, Retinoic Acid, Tretin-X, Tretinoin, Tretinoin Acid, Differin, Epiduo, Amnesteem, Claravis, Sotret, Tazorac, Ziana Gel
Topical Antifungal Agents	Penlac, Cyclopirox 8% Solution
Systemic Antifungals to Treat Nail Infections	Diflucan, Fluconazole, Itraconazole, Lamisil, Sporanox, Terbinafine
Nonsedating Antihistamines	Allegra, Allegra-D, Fexofenadine, Fexofenadine-PSE ER 60-120 Tab, Allegra ODT, Allegra 30MG/5ML Suspension, Clarinex, Clarinex-D, Xyzal,
Leukotriene Receptor Antagonists	Singular

Corticosteriod Nasel Sprays	Beconase AQ, Flonase, Fluticasone, Nasacort, Nasacort AQ, Nasarel, Flunisolide, Nasonex, Omnaris, Rhinocort Aqua, Vancenase AQ, Veramyst
Hormonal Replacement	Cenestin, Enjuvia, Estinyl, Estrace, Estradiol, Estropipate, Ethinyl Estradiol, Femtrace, Gynodiol, Menest, Ogen, Ortho-Est, Premarin, Estring, Femring, Premarin, Estrace, Vagifem, Alora, Climara, Divigel, Elestrin, Esclim, Estraderm, Estradiol, Estradiol Transdermal Patch, Estrasorb, Estrogel, Evamist Spray, Menostar, Vivelle, Vivelle-Dot, Covaryx, Covaryx H.S., EEMT, EEMT HS, Essian, Essian H.S., Estratest, Estratest H.S., Estrogen & Methyltestosterone, Syntest D.S., Activella, Angeliq, Femhrt, Ortho-Prefest, Prefest, Premphase, Prempro, Climara Pro, Combipatch, Aygestin, Medroxyprogesterone Acetate, Megace ES, Norethindrone Acetate, Prometrium, Provera, Android, Androxy, Fluoxymesterone, Methitest, Methyltestosterone, Striant, Testred, Virilon, Androderm, Androgel, First-Testosterone, First-Testosterone MC, Testim, Testosterone, Testosterone Cypionate, Testosterone Propionate
Attention Deficit Disorder treatments for adults (age 19 and over)	Adderall, Adderall XR, Amphetamine Salt Combo, Desoxyn, Dexedrine, Dextroamphetamine Sulfate, Dextroamp-Amphet ER, Destrostat, Liquadd 5 MG/MLSolution, Methamphetamine HCL, Vyvanse, Concerta, Cylert, Daytrana, Dexmethylphenidate, Focalin, Focalin XR, Metadate CD, Metadate ER, Methylin, Methylin ER, Methylphenidate, Methylphenidate ER, Methylphenidate HCL, Methylphenidate HCL SR, Pemoline, Ritalin, Ritalin LA, Ritalin-SR, Strattera
NOTE: This list is subject to on-going change as medications are developed, changed or become available without a prescription.	

Coverage for prescription medications used primarily to enhance lifestyle-related activities such as sexual performance, smoking cessation and dieting are excluded from the Plan.

Food and Drug Administration (FDA) Dose and Quantity Standards

The Food and Drug Administration (FDA) provides recommended safety standards concerning topics such as age-related dosages and quantity limitations for prescription medications. All pharmacy benefit carriers that administer Procter & Gamble prescription medication benefits will utilize FDA standards as a basis for determining claims coverage for eligible employees and family members. Individuals who have prescriptions that do not follow FDA standards will be notified by the pharmacist of the need to have their prescribing provider contact the prescription medication carrier before coverage will be considered for prescriptions that do not follow FDA standards.

Prior Authorization Requirements

There are prior authorization guidelines for a number of prescription medications. Prior authorization involves communication in writing or by phone between the prescribing provider and the Prescription Carrier in order for the prescription to be approved. Contact the Prescription Carrier to obtain specific details concerning when and how prior authorization should be obtained.

The prescription medications which require prior authorization include:

Medication Description
Rheumatoid Arthritis - Abatacept (Orencia), Adalimumab (Humira), Anakinra (Kineret), Etanercept (Enbrel), Infliximab (Remicade), Leflunomide (Arava), Certolizumab Pegol (Cimzia), Golimumab (Simponi)
Interferon Therapy - Interferon Alfa-2A,Recomb. (Roferon-A), Interferon Alfa-2B,Recomb. (Intron-A), Interferon Alfacon-1 (Infergen), Peginterferon Alfa-2A (Pegasys), Peginterferon Alfa-2B (Peg-Intron), Ribavirin (Rebetol, Copegus, Ribasphere)
Growth Hormone and Related Therapies -Growth Hormones (Nutropin, Norditropin, Genotropin, Humatrope, Geref, Nutopin AQ, Somatropin, Somatrim, Protropin, Saizen, Tev-Tropin, Zorbitive), Sermorelin Acetate (Geref Diagnostic)
Acne - Adapalene (Differin), Tazarotene (Tazorac), Tretinoin (Retin-A, Avita, Tretin-X, Ziana)
ADD/ADHA - Amphetamine Mixutre (Adderall), Amphetamine Extended Release Mixture (Adderall XR), Dextroamphetamine (Dexedrine, Dextrostat), Lisdexamfetamine (Vyvanse), Methamphetamine (Desoxyn)
Antifungal Therapy - Itraconazole (Sporanox), Terbinafineine HCL (Lamisil), Fluconazole (Diflucan)
Proton Pump Inhibitors - Proton Pump Inhibitors Step Therapy (Aciphex, Rabeprazole, Nexium, Esomeprazole, Kapidex, Prevacid, Lansoprazole, Prilosec, Omeprazole, Protonix, Pantoprozole, Zegrid, Omeprazole
Anabolic Steriods - Oxandrolone (Oxandrin), Oxymetholone (Anadrol-50), Stanozolol (Winstrol)
Asthma and Allergic Rhinitis - Omalizumab (Xolair), Montekulast (Singulair)
Pulonary Arterial Hypertension - Sildenafil Citrate (Revatio), Tadalafil (Adcirca)
Antidepressants - Bupropion HCL (Wellbutrin SR and XL)
Influenza Therapies (post-limit PA) - Tamiflu (Oseltamivir), Relenza (Zanamivir)
NOTE: This list is subject to on-going change as medications are developed, changed or become available without a prescription.

Home Delivery

When your doctor prescribes a maintenance medication for you, you may use a local retail pharmacy or the Prescription Plan Carrier's home delivery prescription program to fill the prescription. The home delivery prescription program offers a number of advantages including:

- the ability to obtain larger quantities of maintenance medications. The home delivery prescription program allows for up to a 90-day supply per medication, while the retail plan is limited to no more than a 34-day supply at one time;
- lower cost to you and the Company due to higher discounts on home delivery medications;
- the convenience of using the telephone or internet to order your refills.

When you use the home delivery prescription program, the Plan coverage is as follows:

Level I Prescription Medications: 100% of covered charges after a 30% employee co-insurance ($3 minimum, $150 maximum) per prescription, 90-days supply maximum.

Level IA Prescription Medications: 100% of covered charges after a 15% employee co-insurance ($3 minimum, $150 maximum) per prescription, 90-days supply maximum.

Level II Prescription Medications: 100% of covered charges after a 50% employee co-insurance ($3 minimum, no maximum) per prescription, 90-days supply maximum.

The maximum days' supply of prescription medication which may be purchased through home delivery is a 90-days supply per prescription.

In cases of extended business travel outside of the US, an exception to the quantity limit may be requested. Federal regulations may prohibit limit exceptions for certain medications. Your co-insurance for exceptions will be based on the days supply requested (for example, for Level I medications, each 34 days = 30% up to $150).

Your Prescription Plan Carrier may accept certain credit cards. You may also pay your co-insurance by check or money order. If paying by check or money order, you will need to call your Prescription Plan Carrier prior to mailing your order to find out how much your co-insurance will be.

To use the home delivery prescription program, you should:

- obtain 2 prescriptions from your doctor if you need to start taking your medication immediately. One prescription should be for a short-term 1-month supply that you can have filled at a local pharmacy, and the other for a 90-day supply to be filled through the home delivery prescription program;
- obtain an order form by calling your Prescription Plan Carrier or logging on to their website. Active employees with intranet access may also obtain forms from the Benefits section of the P&G intranet;
- complete the order form by providing all information that is required on the front and back of the form; and
- send the order form, the 90-day prescription and the correct co-insurance to your Prescription Plan Carrier. If you are paying by credit card, you will receive a detailed receipt with your order.

NOTE: Your physician may call or fax in your prescription. Your prescription order will be held on file until your order form and co-insurance are received.

First Class Mail or United Parcel Service (UPS) will return your order to you. You should receive your delivery in approximately 14 days. To avoid delays in delivery, be sure that you have provided all of the needed information on the order form, and included the correct co-insurance with your order. Medications that are temperature sensitive will be packaged to avoid temperature exposure. Controlled medications such as narcotics will require an adult's signature for delivery.

In many cases, generic versions of your prescribed medication may be available. While the active ingredients and therapeutic effects of the generic versions may be the same as the brand name version, the cost of the generic version can be significantly lower. In order to contain costs to you and the Company, if a generic version is available, your Prescription Plan Carrier home delivery prescription program will use it to fill your prescription unless your physician or you request brand-name-only medications. There is an area on the physician's prescription form and the Prescription Plan Carrier home delivery prescription program order form to designate your preference for brand.

Prescription medication co-insurance is not applied toward your medical care deductible or your medical out-of-pocket maximum.

The home delivery prescription program is a benefit offered to Procter & Gamble employees and their eligible family members that lowers the prescription medication costs for the employees and our Company. Use of programs such as the home delivery prescription medication program is what is needed to contain the soaring health care costs that ultimately result in increased premiums for employees.

Retail Pharmacies

For most prescriptions or refills, coverage is up to a 34-day supply. The Plan covers a number of prescription medications identified as *generic medications*. At your discretion, these may be substituted for the brand written on the prescription. Since generic medications usually cost less than brand name medications, your co-insurance will be lower.

When you use retail pharmacies, the Plan coverage is as follows:

Level I Prescription Medications: 100% of covered charges after a 30% employee co-insurance ($3 minimum, $50 maximum) per prescription, 34-days supply maximum.

Level IA Prescription Medications: 100% of covered charges after a 15% employee co-insurance ($3 minimum, $50 maximum) per prescription, 34-days supply maximum.

Level II Prescription Medications: 100% of covered charges after a 50% employee co-insurance ($3 minimum, no maximum) per prescription, 34-days supply maximum.

The maximum days supply of prescription medication which may be purchased through retail pharmacies is a 34-days supply per prescription. However, the Plan has identified a number of prescription medications that by law have a maximum dispensing limit that is less than the 34-days supply. Compliance to these limits is required.

In cases of extended travel to regions where participating pharmacies are not available, an exception to the quantity limit may be requested. Federal regulations may prohibit limit exceptions for certain medications. Your co-insurance for exceptions will be based on the days supply requested (for example, for Level I medications, each 34 days = 30% up to $50).

Note: Reduced benefits may be paid if you obtain your prescription or refill at a non-participating pharmacy. Check with the pharmacist to confirm whether or not the pharmacy participates in the prescription plan's network.

Specialty Medication Pharmacy Services

Your Prescription Plan Carrier offers a full-service Specialty Pharmacy providing convenient ordering and individualized assistance from a pharmacist or nurse and fast delivery of specific injectable and oral medications.

Your Prescription Plan Carrier Specialty Pharmacy program provides prescription medications that are used to treat conditions such as multiple sclerosis, hemophilia, hepatitis C, immune deficiency, cystic fibrosis, rheumatoid arthritis, infertility, blood cell deficiency, and deep vein thrombosis. Treatment of these and other conditions involve the use of specialty medications that often:

- require individualized dosages
- need special packaging to preserve quality and effectiveness
- may be self-injected or
- are known to cause serious side effects that can be reduced through appropriate patient education.

When you use Specialty Medication Pharmacy Services, the Plan coverage is as follows:

Level 1 Medications: 100% of covered charges after a 30% employee co-insurance (**$3 minimum, $25 maximum**) per prescription, 34-days supply maximum.

Level 1A Medications: 100% of covered charges after a 15% employee co-insurance (**$3 minimum, $25 maximum**) per prescription, 34-days supply maximum.

Level II Medications: 100% of covered charges after a 50% employee co-insurance (**$3 minimum, no maximum**) per prescription, 34 days supply maximum.

Your Prescription Plan Carrier Specialty Pharmacy program provides informative materials and access to pharmacists and other health care experts to help patients understand their medication therapy and stay as healthy as possible. In addition, the Specialty Pharmacy program can help manage the costs of these specialty medications, which tend to be unusually expensive to both the patient and P&G. The Specialty Pharmacy program provides the individualized attention needed to promote the best possible treatment outcomes for the patients receiving these therapies. During the entire treatment period, patients will receive one-to-one counseling from a Specialty Pharmacy program pharmacist or nurse who has received in-depth training concerning the patient's specific medication and condition. The pharmacist or nurse will provide details concerning the side effects that may be experienced while taking the medication, how to reduce or alleviate the side effects, and special steps or safety precautions for storing or using the medication. If the patient experiences problems while taking the medication, they may request that a pharmacist or nurse contact their physician on their behalf to discuss needed care such as changes in dosage, medications to reduce side effects, etc.

To take advantage of individualized care benefits through your Prescription Plan Carrier Specialty Pharmacy program, patients or their physicians may call your Prescription Plan Carrier Specialty Pharmacy Services to discuss the details concerning a specialty medication prescription or refill. All of the supplies needed to use the medication, such as alcohol wipes, needles, syringes, and needle disposal kits will be delivered with the medication, at no additional cost to the patient. The patients may choose to have the medication and supplies delivered to their home, their work location, their physician's office, or even to their hotel when vacationing.

The Specialty Pharmacy program will save you time and claims payment hassles by submitting insurance claims for you and assisting you with any difficulties you may experience in coordinating coverage between multiple insurance plans.

Prescription Medications Not Covered

Expenses for certain medications or services are **not** available through the Prescription Medication Plan, including:

- administration/injection - practitioner's fees for administration or injection of any prescription medication or medicine (medical benefits may apply);
- allergy serums and allergens (medical benefits may apply);
- biological sera except for clotting factors obtained through Specialty Pharmacy Services (medical benefits may apply);
- blood or blood plasma except for clotting factors obtained through Specialty Pharmacy Services (medical benefits may apply);
- claims filed after claims filing deadline as described in the Procedures > Claims section of this Plan;
- convalescent facility/nursing home - prescription medications provided for use in a convalescent facility or nursing home which are ordinarily furnished by such facility for the care and treatment of patients;
- cosmetic purposes - medications used primarily for cosmetic purposes, e.g. Rogaine and in certain cases Retin A;
- coverage date - services or supplies provided before the effective date of coverage or after the termination of coverage;
- days supply - home delivery (mail order) - charges for more than 90 days supply of prescription medications obtained via home delivery;
- days supply - retail - charges for more than 34 days supply of prescription medications obtained at retail pharmacies;
- delivery charges;
- exclusions - any expense excluded by the Plan;
- experimental/investigational - medications used for experimental or investigation purposes;

- FDA-approved purposes - medications used for purposes that are not FDA approved unless reviewed and approved with prior authorization;
- FDA-medications that are not approved for general sale by the U.S. Food and Drug Administration (FDA);
- foreign country prescription medication services - non-emergency services rendered outside of the United States or U.S. sovereign territories. Coverage is provided for covered members who experience emergency illness or injury while on temporary travel to foreign countries;
- growth hormones except when determined to be medically necessary by the Plan;
- hospitalization - prescription medications used as an inpatient or outpatient in a hospital which are ordinarily furnished by such facility for the care and treatment of patients;
- immunizations (medical benefits may apply);
- infant formula with or without prescription;
- licensure - medications that are not dispensed by a licensed pharmacist or physician;
- lifestyle-related activity enhancement - medications used to enhance lifestyle-related activities such as sexual function or performance, dieting, and smoking cessation;
- medical condition - medications and supplies when not indicated or prescribed for a medical condition as determined by the Plan or otherwise specifically covered under the Plan;
- medical supplies, devices and equipment and nonmedical supplies or substances regardless of their intended use except for diabetic devices, supplies and equipment covered under the Plan;
- non-covered expenses - expenses for medications that have been determined as non-covered through authorization, concurrent or retrospective review, and/or appeal review;
- nutritional supplements except in situations where supplements are the only source of nutrition for an individual and the condition was caused by a medical disease or injury;
- over-the-counter - medications which can be purchased over the counter (without a prescription);
- packaging - convenience packaging charges/extra costs;
- payment - any covered medication, device, or apparatus for which you are not legally obligated to pay or for which no charge is made;
- payment - charges which are in excess of the contracted amount;
- payment - prescription medications that may be received without charge under local, state or federal programs, including Worker's Compensation;
- payment - prescription medications when another plan, person or third party has the obligation to provide funds for payment;
- payment - prescription medications when, in the absence of this certificate you would not be charged;
- prescription medications that are 100% equivalent in active and inactive ingredients to an over-the-counter medication, but have a different name than the OTC;
- prescription order requirement - medications that do not require a prescription order and/or which are not prescription legend medications, except insulin;
- refills - any refill in excess of the amount specified by the prescription order. Before covering charges, the Plan may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards or FDA standards;
- refills dispensed more than one year from the date of the prescription;
- replacement medications resulting from loss, theft, or damage;
- residency - medications or services for employees or retirees and dependents residing outside of the United States or U.S. sovereign territories;
- skin pigmentation - pigmenting or depigmenting agents;
- smoking cessation - medications or devices used to assist with smoking cessation;
- test agents and devices (exception - diabetic test agents);
- United States - medications obtained outside of the United States or U.S. sovereign territories (exception - medications required as part of one-time emergency or urgent care treatment);
- vitamins or minerals, except those which by federal law require a prescription for dispensing;
- weight loss - medications used to assist with weight loss;

- work-connected injuries or diseases - prescription medications or supplies used to treat work connected injuries or diseases eligible for coverage by Worker's Compensation or similar law or eligible for Medicare payment, whether or not coverage is elected.

Procedures (How To)

Appeals

The Trustees or Plan Fiduciary has the discretionary authority to interpret the terms of this Plan, to determine the facts underlining any benefits claims, and to determine eligibility for and entitlement to Plan benefits in accordance with terms of this Plan. Determination by the Trustees or Plan Fiduciary as to the interpretation and application of this Plan in any particular case shall be conclusive on all interested parties and their action shall not be subject to any review.

Enrollment Appeals

If you would like to appeal a denial of your request to enroll yourself or a family member, you should appeal in writing to the Active *Healthcare Benefits Manager*.

You should include the following information in your letter of appeal of a denial of a request for enrollment:

- Employee Identification Number;
- Employee daytime telephone number;
- Employee work location;
- Name of individual who was denied enrollment;
- Relationship of individual to employee;
- A brief explanation of why you disagree with the information given in the denial.

You will be given two opportunities to appeal a denial of your request to enroll yourself or a family member. The second appeal will not be decided by the individual who determined the outcome of your first appeal.

Claims Appeals

You may also want to appeal certain decisions made by the Plan. If you believe that your claim for benefits has been unfairly denied or reduced, you may request that the claim be reviewed. You may also request a review if you submit a treatment plan and disagree with the decision concerning coverage of any or all aspects of the treatment plan.

Appealing a Denied or Reduced Claim for Medical Benefits

The reason your claim was denied or benefits were reduced is indicated on the Explanation of Benefits, (EOB) that you received from your *Medical Carrier*. You have the right to appeal a claim denial or payment reduction if you feel that the reasons for the denial or reduction are not valid. Your first step is to call the Medical Carrier customer service line to attempt to resolve any differences. This initial call does not qualify as an appeal. If you are not satisfied with the resolution of your call, you should file an appeal in writing to the Medical Carrier.

In order for your appeal to be considered, you must file your written appeal within 180 days of the service. You should attach copies of any documents concerning your case, and include the following information in your appeal letter:

- Patient Name
- Subscriber Name
- Subscriber ID #
- Date of Service
- Provider's Name
- Claim Number (located on the EOB)
- The reason for your appeal

During the appeal process, you are entitled to review all appropriate plan documents and to have a qualified person represent you. You will be notified of the decision concerning your appeal.

If you are not satisfied with the outcome of your first written appeal, you may file a second written appeal with the Medical Carrier.

Those involved in the first appeal decision will not decide the second appeal. In this letter, you should describe the problem in detail, and attach copies of any documents you have concerning your case. You will be notified of the decision concerning your appeal.

Procter & Gamble will not be involved in decisions concerning denied or reduced claims, and will not accept appeals.

Appealing a Denied or Reduced Claim for Prescription Medications

For retail and home delivery appeals contact your *Prescription Plan Carrier* .

You have the right to appeal a claim denial or payment reduction if you feel that the reasons for the denial or reduction are not valid. Your first step is to call the Prescription Plan Carrier customer service line to attempt to resolve any differences. This initial call does not qualify as an appeal. If you are not satisfied with the resolution of your call, you should file an appeal in writing to the Prescription Plan Carrier.

In order for your appeal to be considered, you must file your written appeal within 180 days of the service. You should attach copies of any documents concerning your case, and include the following information in your appeal letter:

- Patient Name
- Subscriber Name
- Subscriber ID #
- Date of Service
- Provider's Name
- Claim Number (located on the EOB)
- The reason for your appeal

During the appeal process, you are entitled to review all appropriate plan documents and to have a qualified person represent you. You will be notified of the decision concerning your appeal.

If you are not satisfied with the outcome of your first written appeal, you may file a second written appeal with the Prescription Plan Carrier.

Those involved in the first appeal decision will not decide the second appeal. In this letter, you should describe the problem in detail, and attach copies of any documents you have concerning your case. You will be notified of the decision concerning your appeal.

Procter & Gamble will not be involved in decisions concerning denied or reduced claims, and will not accept appeals.

Appealing a Pre-certification/Authorization for Care Decision

If you or your attending physician disagrees with a decision regarding the appropriateness of a treatment plan, or the necessary length of services, contact your *Medical Plan Carrier* for the procedure to appeal the decision. If agreement cannot be reached, it is your decision on whose advice to follow. The Plan, however, will pay benefits according to the decision made by the claim administrator.

Procter & Gamble will not be involved in decisions concerning pre-certification/authorization of care and will not accept appeals.

Assignment

Payments to most physicians and hospitals may be *assigned*. However, payments to pharmacies may **not** be assigned.

For additional information on which benefits may be assigned and the process to assign benefits, contact your *Medical Plan Carrier*.

Change of Address

To change your address on-line, visit the P&G intranet. If you do not have intranet access, contact the *Employee Service Center* to change your address.

Address changes will be shared throughout the Company except CBD-related databases (i.e. sales materials) and Shareholder Services.

Claims

How you file a claim depends upon whether you received your care *in-network* or *out-of-network*.

When you receive **in-network** medical care or a prescription from a participating pharmacy, you do **not** have to file any claims for reimbursement. Network providers submit claims directly to your Plan. Usually, you pay the applicable co-payment or co-insurance at the time service is rendered and the provider handles all of the paperwork.

However, if you receive care **out-of-network**, either you or the provider must file a claim to apply for reimbursement for out-of-network covered expenses.

To file a claim:

- obtain a claim form from the P&G Intranet and complete the employee section;
- sign the form and give it to the provider with instructions to finish completing the form (if necessary) and send it to the Carrier. If your provider uses a pre-printed form, you may attach it to the claim form;

- attach a copy of the itemized bill with a completed claim form providing a brief explanation of the services you received, the date the charge was incurred and the amount of the charge;
- include your name and subscriber identification number;
- make sure a diagnosis is provided to ensure prompt processing of your claim; and
- if you have received services from a nurse or therapist, your claim should include a statement from your doctor explaining why these services were needed.

You should consider the following when filing a claim:

- your bills do not have to be paid before you file a claim. However, some providers may require payment in full at the time of service. **Be sure to include a bill, not just a cancelled check**;
- you may designate benefits to be paid directly to you or to the provider; and
- file separate claims for each family member and for each provider.

Keep copies for your records of any documents you send.

In order to receive coverage, all claims should be filed within 90 days after you, or anyone covered by the plan, receives a covered service or supply. You must file a claim for covered medical, prescription or EAP services **no later than** one year after this 90-day period.

In exercising its fiduciary responsibilities, the Plan administrator, carrier or Healthcare Plan Committee shall have complete and discretionary authority to determine whether and to what extent participants and beneficiaries are eligible for benefits and to construe disputed Plan terms.

If your claim is denied, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

Contact your *carrier* for more details.

Checking Status/Processing Time

You should receive any reimbursement, or if you assigned benefits, notification of payment to the provider, as soon as possible, but no later than 90 days after a claim is filed.

For information on the status of a claim, contact your *carrier*.

Enrollment

P&G's benefit enrollments are administered on a calendar year basis (January 1 - December 31).

In general, you may enroll within 30* days of your initial eligibility. You may also enroll during *Annual Enrollment*.

In addition to meeting all eligibility requirements, the timing of your enrollment request may impact your enrollment opportunity. For instance, in some circumstances, if you miss the 30 day enrollment opportunity, you may not request enrollment again until the next Annual Enrollment period. Refer to the When Coverage Begins and When Coverage Ends pages in this Plan for details. The *Employee Service Center* will determine whether your requested enrollment or change in coverage is consistent with the enrollment situation you have experienced and whether the timing of your enrollment request impacts your opportunity to enroll.

To enroll in this Plan, or to make a change to your benefits outside of the Annual Enrollment Period (due to an eligible special enrollment situation), use the appropriate checklist from the P&G intranet. These checklists should be used as a resource to guide you through everything you need to consider, including managing paperwork and updating your compensation and benefit status. If you have any questions once you have read the material in the checklists you may contact the Employee Service Center.

You may elect different participant levels for medical/prescription/EAP and dental coverage (i.e. family Dental and employee-only Medical/Prescription/EAP). An enrollment change in the medical/prescription/EAP plan does not automatically change enrollment in the dental plan. Likewise, an enrollment change in the dental plan does not automatically change enrollment in the medical/prescription/EAP plan. If you wish to change enrollment in both the medical/prescription/EAP and dental plans, you will have to change each plan individually.

You **must** elect the same participation levels for Medical and Prescription Medication coverage, as these plans are offered as a package.

If you are an employee eligible for domestic partner and/or household dependent benefits, be sure to review the Additional Enrollment Information - Domestic Partner and/or Household Dependent page for specific details regarding enrollment.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

Eligibility for all domestic partners and/or household dependents is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a domestic partner and/or household dependent who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30 days** of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a domestic partner - legal tax dependent and/or household dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year. Please also see the Domestic Partner and Household Dependent Eligibility rules for more information regarding specific eligibility and enrollment requirements that apply to these groups.

*** Fully insured health care plans operate according to the carrier's rules. Employees enrolling in these plans should contact the carrier for information.**

Annual Enrollment

During Annual Enrollment, all eligible employees may enroll in or drop any coverage desired (according to eligibility and Plan rules), for an effective coverage date of the beginning of the next Plan year.

Employees will be provided with a notice announcing the Annual Benefits enrollment and instructions on how to access the enrollment materials.

Often, if you do not enroll, and the Plan offering is not changing, your current elections for health care (ie. medical, etc.) will automatically carry over to the next year with any new rates which apply.

Note: If your current health care plan is no longer offered by your site as of December 31st, or the Plan is holding a mandatory enrollment period, you must select a new plan during this enrollment in order to be covered for the new Plan Year.

You may print a confirmation of your online enrollment from the Benefits section of the P&G intranet.

If you are an employee eligible for domestic partner and/or household dependent benefits, be sure to review the Additional Enrollment Information - Domestic Partner and/or Household Dependent page for specific details regarding enrollment.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

Eligibility for all domestic partners and/or household dependents is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a domestic partner and/or household dependent who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30 days** of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a domestic partner - legal tax dependent and/or household dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year. Please also see the Domestic Partner and Household Dependent Eligibility rules for more information regarding specific eligibility and enrollment requirements that apply to these groups.

New Hire Process

New Hire enrollments are considered Special Enrollment Situations - Initial Employee Eligibility opportunities.

In addition to meeting all eligibility requirements, the timing of your enrollment request may impact your enrollment opportunity. For instance, in some circumstances, if you miss the 30 day enrollment opportunity, you may not request enrollment again until the next Annual Enrollment period. Refer to the When Coverage Begins and When Coverage Ends pages in this Plan for details. The *Employee Service Center* will determine whether your requested enrollment or change in coverage is consistent with the enrollment situation you have experienced and whether the timing of your enrollment request impacts your opportunity to enroll.

Generally, within five business days of your date of hire, you are expected to enroll in P&G benefits. If you have any questions once you have read the material provided, you may contact the Employee Service Center.

If you are hired between 9/15 and 1/1, you should also receive an Annual Enrollment opportunity after you have completed your New Hire enrollment. Contact the Employee Service Center if you do not receive this opportunity or have questions about these materials provided.

If you are an employee eligible for domestic partner and/or household dependent benefits, be sure to review the Additional Enrollment Information - Domestic Partner and/or Household Dependent page for specific details regarding enrollment.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

Eligibility for all domestic partners and/or household dependents is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a domestic partner and/or household dependent who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30 days** of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a domestic partner - legal tax dependent and/or household dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year. Please also see the Domestic Partner and Household Dependent Eligibility rules for more information regarding specific eligibility and enrollment requirements that apply to these groups.

*** Fully insured health care plans operate according to the carrier's rules. Employees enrolling in these plans should contact the carrier for information.**

Special Enrollment Situations

A Special Enrollment Situation is an event that permits you to make certain changes to your benefit elections outside of *Annual Enrollment*. These situations are subject to Federal Regulations and may affect enrollment in the P&G Health Care Plans (medical, dental, etc.).

In addition to meeting all eligibility requirements, the timing of your enrollment request may impact your enrollment opportunity. For instance, in some circumstances, if you miss the 30 day enrollment opportunity, you may not request enrollment again until the next Annual Enrollment period. Refer to the When Coverage Begins and When Coverage Ends pages in this Plan for details. The *Employee Service Center* will determine whether your requested enrollment or change in coverage is consistent with the enrollment situation you have experienced and whether the timing of your enrollment request impacts your opportunity to enroll.

To enroll in this Plan, or to make a change to your benefits outside of the Annual Enrollment Period (due to an eligible special enrollment situation), use the appropriate checklist from the **P&G intranet**. If you have any questions once you have read the material in the checklists you may contact the Employee Service Center.

Note: Depending on your site, when you enroll dependents, verification (i.e., birth certificate, legal court papers, dependent support test, marriage license, etc.) may be requested.

Special Enrollment Situations can be broadly categorized as Initial Eligibility Situations and Special Enrollment Situations (mid-year enrollment changes). The chart below provides an overview of various Special Enrollment Situations and the potential actions permitted due to the situation. **The timing of your enrollment may impact the potential action(s) permitted.**

Initial Employee Eligibility Situations				
		Add	Drop	Continue
New Hire	Full-Time New Hire	HC		
	Intern/Co-op Hire	HC		
	Part-Time Hire	HC		
International Transfer	Expatriate Domestic Transfer	HC		HC
	Leaving U.S. (Non-U.S. Employee Ends International Assignment)		HC	
	Local to Local In	HC		
	Local to Local Out		HC	
	Personal Request International Transfer into U.S.	HC		
	Returning to U.S. (U.S. Employee ends International Assignment)	HC		
	Transfer into U.S. (Non-U.S. Employee Begins International Assignment)	HC		
	Transfer out of U.S. (U.S. Employee Begins International Assignment)		HC	
	Transfer to Local (Non-U.S. Employee on International Assignment Localizes to U.S.)	HC		
Special Enrollment Situations (Mid Year Enrollment Changes)				
		Add	Drop	Continue
Add a Newly Eligible Dependent	Children (under age 19)-Adoption, Birth, Legal Custody, Stepchildren	HC		
	Marriage	HC		
Dependent Child turns age 25 and is eligible as a household dependent				HC
Drop a Dependent Due to Loss of Eligibility	Children-Dependent Child Marries, Turns Age 19 and is No Longer Dependent on you for More Than 1/2 of Their Support or Turns Age 25		HC	

	Death of Dependent		HC	
	Divorce or Legal Separation		HC	
	Enrolled Domestic Partner and/or Household Dependent no Longer Meets 1 or More Eligibility Requirements		HC	
Eligible Dependent Change in Employment			HC	
Eligible Employee/Dependent Loss of non-P&G Health Care Coverage		HC		
Eligible Employee/Dependent Gain of non-P&G Health Care Coverage			HC	
Employee Change in Employment Status or Work Schedule	Begin Less Than Full-Time (LTFT) Schedule	HC	HC	
	Child Care Leave of Absence			HC
	Domestic Transfer (consistent with move)	HC	HC	
	End Less Than Full-Time (LTFT) Schedule-Return to Full-Time	HC	HC	
	Full-Time to Part-Time Employment Status Change		HCtd>	
	Leaves of Absence (formerly Personal Leave)			HC
	MBA Leave of Absence			HC
	Military Leave of Absence			HC
	Part-Time Account Representative to Part-Time Retail Merchandiser		HC	
	Part-Time Account Representative Work Schedule Change	HC	HC	
	Part-Time Employee Reaches 1,000 Hours	HC	HC	
	Part-Time Employee with 1,000 Hours Works Less Than 1,000 Hours		HC	
	Part-Time Retail Merchandiser to Part-Time Account Representative	HC		
	Part-Time to Full-Time Employment Status Change	HC	HC	

	Retirement		HC	
	Return From Leave of Absence	HC	HC	
	Spousal Leave of Absence		HC	HC
	Technical Education Leave of Absence		HC	HC
	Termination		HC	

If you are an employee eligible for domestic partner and/or household dependent benefits, be sure to review the Additional Enrollment Information - Domestic Partner and/or Household Dependent page for specific details regarding enrollment.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

***Fully insured health care plans operate according to the carriers' rules. Employees enrolling in these plans should contact the carrier for information.**

Eligibility for all domestic partners and/or household dependents is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a domestic partner and/or household dependent who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30 days** of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a domestic partner - legal tax dependent and/or household dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year. Please also see the Domestic Partner and Household Dependent Eligibility rules for more information regarding specific eligibility and enrollment requirements that apply to these groups.

Transferred Employee Process

Non-International Transferred Employee enrollments are considered *Special Enrollment Situations* - (Mid-Year Enrollment Changes) opportunities.

In addition to meeting all eligibility requirements, the timing of your enrollment request may impact your enrollment opportunity. For instance, in some circumstances, if you miss the 30 day enrollment opportunity, you may not request enrollment again until the next Annual Enrollment period. Refer to the When Coverage Begins and When Coverage Ends pages in this Plan for details. The *Employee Service Center* will determine whether your requested enrollment or change in coverage is consistent with the enrollment situation you have experienced and whether the timing of your enrollment request impacts your opportunity to enroll.

You are expected to use the appropriate checklist from the **P&G intranet** to make changes to your benefits as a result of your transfer. These checklists should be used as a resource for information about our many benefit plans, as well as to provide you with forms and links to enroll or change enrollment in any plans for which you are eligible. If you have any questions once you have read the material, you may contact the Employee Service Center.

- P&G health care plans may offer a choice of plan options depending on your work location code. If your transfer requires you to change health care plans, you may review your choices on P&G intranet;
- If an employee has dependents who will relocate after the transfer date, the employee and the family have the option to remain in health care coverage at the sending site for a maximum of 12 months, with the agreement of the sending site. The employee must call the Employee Service Center to discuss extending coverage. (If the employee requires health care services in the new location during the twelve month period, use of out-of-network providers will result in out-of-network coverage.);
- Enrollment in the health care plan of the new site **before** the transfer date is not permitted. However, you should enroll within 30 days of your transfer to the new site. Except as noted above, employees and/or dependents are not permitted to remain in coverage at the former location.

Generally, if you are transferred between 9/15 and 1/1, you should also receive a separate Annual Enrollment opportunity. Contact the Employee Service Center if you do not receive this opportunity or have questions about provided materials.

If you are an employee eligible for domestic partner and/or household dependent benefits, be sure to review the Additional Enrollment Information - Domestic Partner and/or Household Dependent page for specific details regarding enrollment.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

Eligibility for all domestic partners and/or household dependents is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a domestic partner and/or household dependent who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30 days** of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a domestic partner - legal tax dependent and/or household dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year. Please also see the Domestic Partner and Household Dependent Eligibility rules for more information regarding specific eligibility and enrollment requirements that apply to these groups.

*** Fully insured health care plans operate according to the carrier's rules. Employees enrolling in these plans (Hawaii residents only) should contact the carrier for information.**

Waiving Coverage

If coverage is waived when you (or your eligible dependents) are first eligible, or during Annual Enrollment, you (or your eligible dependents) must meet the following conditions to enroll in the future (except during a subsequent Annual Enrollment). Eligible dependents must also continue to meet eligibility requirements. You must:

- provide documentation showing that coverage was provided through another employer group health plan during the entire waiver period;
- apply within 30 days of the loss of other coverage; and
- provide documentation showing the other coverage ended as a result of termination of employment, retirement, divorce, death of a spouse, ineligibility for further coverage or termination of the plan.

If you are an employee eligible for domestic partner and/or household dependent benefits, be sure to review the Additional Enrollment Information - Domestic Partner and/or Household Dependent page for specific details regarding enrollment **and waiving coverage**.

Health Insurance Portability and Accountability Act (HIPAA) Certificate

The Certificate of Creditable Coverage is issued when:

- you submit a Health Care Enrollment/Change Form to drop a dependent or yourself from coverage; or
- you terminate employment with Procter & Gamble.

When you begin a new job, or enroll in new health care, be sure to contact your new employer or health plan administrator as soon as possible to see if they need the certificate. If your new health plan does not require the certificate, you should keep it in your records until you need it.

Contact the *HIPAA Administrator* if you or your dependent drop coverage but do not receive a Certificate of Creditable Coverage.

Note:
If you lose your certificate within 24 months of your health care coverage end date, be sure to contact the HIPAA Administrator for a duplicate copy. A copy will be mailed to you at no charge.

Pre-certification/Authorization

When specific services, supplies, medications, or treatments are going to be obtained from either *in-network* or *out-of-network* providers, a call must be placed to the Carrier prior to utilization of such services, supplies, medications or treatments, in order to obtain coverage details and/or provide appropriate information needed to correctly administer a claim. *Pre-certification/authorization* does not guarantee that a service, supply, medication or treatment will be covered by the Plan.

The pre-certification/authorization procedure is designed to help you avoid unnecessary, lengthy or costly hospitalizations or treatments when there may be appropriate alternatives.

Each time you receive in-network or out-of-network care, you are responsible for following all pre-certification/authorization procedures. If you fail to call the Carrier for pre-certification/authorization (and the expenses for services are covered by the Plan), your benefits will be reduced by 30%. (Certain prescription medications are not available without appropriate prior authorization.) Refer to the Coverage Information chart to determine the types of services, supplies, medications or treatments that require pre-certification/authorization. If you extend the number of certified hospital days without pre-certification, or if you do not obtain the required pre-certification for inpatient behavioral health services, no benefits will be paid.

Pre-admission pre-certification helps to control inpatient costs by helping you avoid needless or unnecessarily long inpatient stays by:

- reviewing with you possible options such as the outpatient surgery and second opinion provisions that can help hold down health care costs and may affect your benefits;
- reviewing the reasons for an inpatient stay with your doctor to make sure it is necessary. In many cases, such as non-surgical treatment, minor surgery or diagnostic testing, you can receive treatment without a hospital stay;
- making sure that testing is done before the inpatient stay begins, if at all possible;

- assigning an estimated duration for your inpatient stay and monitoring its length; and
- developing alternative treatment options such as *skilled nursing facilities* and comprehensive rehabilitation centers.

If you disagree with a pre-certification/authorization decision, you may appeal the decision by filing an appeal with the Carrier. See the Procedures > Appeals section of this Plan for more information on the appeals process.

In exercising its fiduciary responsibilities, the Plan administrator, carrier or Healthcare Plan Committee shall have complete and discretionary authority to determine whether and to what extent participants and beneficiaries are eligible for benefits and to construe disputed Plan terms.

Behavioral Health Admission

For a **scheduled** *behavioral health* admission, you must contact your *Employee Assistance Program (EAP)* Carrier in order to be covered with no penalty, if services are covered.

For an **emergency** behavioral health admission, you must follow these procedures:

- you must call the EAP, if possible, prior to being admitted. Treatment coordinators are available 24 hours a day;
- if your condition does not permit you to contact the EAP, go to the nearest *urgent care* center (if available in your area) or hospital emergency room;
- if you are admitted to a hospital without pre-certification/authorization by a treatment coordinator, call the EAP within 48 hours;
- to continue receiving benefits, you may be moved to an approved hospital when your condition has stabilized; and
- follow-up care must be pre-certified/authorized by a treatment coordinator at the EAP in order to be covered with no penalty.

If you are, or a dependent receives out-of-network treatment at the time of your emergency, follow the same procedures as above; however, be sure to obtain copies of all bills for any treatment you receive. When you get home, send copies of everything along with a written explanation and your ID number to the EAP.

If you do not obtain the required EAP pre-certification/authorization, payment of claims may incur a penalty.

Emergency Care/Admission

If you are admitted to a hospital because of an emergency, you, your doctor, a family member or a hospital representative should call your Medical Carrier within 48 hours of the admission.

Contact your *Medical Carrier* for more details.

Extending a Hospital Stay

At the time of the initial review of your preadmission *pre-certification/authorization*, a Plan professional will make a recommendation regarding the length of your stay.

One day before your scheduled discharge, the Plan will contact your doctor to determine how many, if any, additional days will be authorized.

If you exceed the number of certified days, the additional days of hospital confinement will not be covered.

Maternity Admission

For a maternity admission, you should contact your *P&G Medical Plan* prior to your due date for admission and *pre-certification/authorization* procedures.

When you are admitted, your physician, the hospital, or a family member should call the Plan again within 48 hours of your admission.

On your last certified day, the hospital will be contacted to determine if you are being discharged. If not, the Plan will contact your physician to determine how many, if any, additional days will be authorized.

If you exceed the number of authorized days, the additional days of hospital confinement will not be covered.

Note:
Group health plans and health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Non-Emergency Admission

The pre-certification/authorization procedure for being admitted to the hospital depends on where and from whom you will be receiving care.

- If you are receiving *in-network* care, generally, your *Network Physician/Provider* will contact your P&G Medical Plan to pre-certify/authorize the stay, however, you are responsible for ensuring pre-certification has been completed.
- If your care is received *out-of-network*, (either at an out-of-network facility or performed by an out-of-network provider), you are responsible for contacting the Plan to complete the required pre-certification/authorization.

Refer to the Coverage Information chart to determine the types of hospitalizations that require pre-certification/authorization. **Before entering the inpatient facility, you should confirm with the Plan that the pre-certification/authorization procedure has been followed.**

To complete pre-certification/authorization, you or your physician must contact the Plan. If you call, have your ID card handy, and be prepared to give:

- the name of the patient and his or her member identification number;
- the diagnosis;
- the date of admission; and
- the name, address and phone number of the patient's doctor.

A written notice of the number of days certified will be promptly sent to you and to the physician. If time is short, your physician and the hospital will be notified by phone.

If you do not follow the required pre-certification/authorization procedures, your benefits will be reduced by 30%.

Readmission to the Hospital

Readmissions to the hospital are treated like any other hospital admission. Refer to the Coverage Information chart to determine the types of hospitalizations that require pre-certification/authorization. You must follow the proper *pre-certification/authorization* procedure. If you do not follow the required pre-certification/authorization procedures, your benefits will be reduced by 30%.

Second Surgical Opinion

A second surgical opinion is designed to help you make informed decisions regarding surgery, thereby avoiding any unnecessary surgeries and treatments. Under the P&G Medical Plan, there are times when experience will indicate an alternative procedure. When this happens, you may arrange to see another participating physician.

If the second opinion does not confirm the need for surgery, you may have a third opinion if you wish.

Refer to the Coverage Information chart for details on how the Plan covers second and third opinions.

Urgent Care

For non-life threatening situations that require *urgent care*, call your primary physician first no matter what time of the day or night for advice. Your primary physician may choose to call in a prescription for you, tell you to come into their office when it opens, or refer you to the nearest area urgent care center or hospital facility.

Predetermination of Benefits

A predetermination of benefits is an **estimate** of benefits payable by the Plan for a specific medical treatment before you receive the treatment. Your benefit amount may vary based on the services actually received at the time the treatment is performed.

Under the Plan, a predetermination of benefits is **not** required, and there is **no** penalty if you do not request one. However, requesting a predetermination of benefits from the Plan will help you estimate the amount of your out-of-pocket expenses **before** you incur the medical expense.

When requesting a predetermination of benefits, you should contact the Plan **several weeks** before your scheduled procedure so they can complete your request in a timely manner.

To request a predetermination of benefits, contact the Plan.

In exercising its fiduciary responsibilities, the Plan administrator, carrier or Healthcare Plan Committee shall have complete and discretionary authority to determine whether and to what extent participants and beneficiaries are eligible for benefits and to construe disputed Plan terms.

Note:
Contacting your P&G Medical Carrier for a predetermination of benefits does **not** eliminate your need to follow the Plan's pre-certification/authorization procedures.

Providers/Primary Physicians

To determine whether your provider, including your primary physician, is a network provider, you may:

- review the provider information on the Carrier's website (if applicable);
- contact the Carrier by phone.

When you seek care from or are referred to a provider, prior to incurring any charges, it is your responsibility to verify whether or not the provider is in-network.

QDRO/QMCSO

Qualified Domestic Relations Order/Qualified Medical Child Support Order

If you receive a court order that affects your benefits, you will need to notify Procter & Gamble. The steps you need to take are based on the type of order you receive.

Qualified Domestic Relations Order (QDRO)

Qualified Domestic Relations Orders (QDRO) are sent to Procter & Gamble directly from the County Court. If you receive a court order that affects your benefits, you should contact the *Employee Service Center* to confirm that Procter & Gamble has received a copy. You will be notified by the Employee Service Center of the steps you need to take based on your QDRO.

Qualified Medical Child Support Order (QMCSO)

Qualified Medical Child Support Orders (QMCSO) are sent to Procter & Gamble directly from the County Court. If you receive a court order that affects your benefits, you should contact the *Employee Service Center* to confirm that Procter & Gamble has received a copy. You will be notified by the Employee Service Center of the steps you need to take based on your QMCSO.

Taxes

Your premiums are deducted on a *pre-tax* basis, unless you enroll a *domestic partner - not a legal tax dependent*. If you enroll a domestic partner who is not your legal tax dependent, Federal regulations require your premiums be paid with after-tax dollars.

Premiums that are pre-tax are taken from pay before Federal, Social Security, and in most cases, state and local taxes are deducted. When you elect to make pre-tax contributions, you agree to have a part of your earnings deducted as contributions before reaching your paycheck, in effect reducing your taxable income. By reducing taxable income, less is owed in taxes; however, this may also reduce future Social Security benefits.

In some cases, you may also incur additional tax liability in the form of *imputed income*, depending on enrollment or disenrollment circumstances.

Imputed Income for Disenrollment Situations

Disenrollment of Household Dependent(s) and/or Domestic Partner - Legal Tax Dependent

A tax liability that you may incur under the Plan is imputed income for a disenrolled *household dependent* and/or *domestic partner - a legal tax dependent*.

Eligibility for all domestic partners and/or household dependents is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a domestic partner and/or household dependent who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30 days** of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a domestic partner - legal tax dependent and/or household dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year. Please also see the Domestic Partner and Household Dependent Eligibility rules for more information regarding specific eligibility and enrollment requirements that apply to these groups.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

Imputed Income for Enrollment Situations

Imputed Income for Enrollment of Domestic Partner - Not a Legal Tax Dependent

A tax liability that you may also incur under the Plan is *imputed income* for enrolling a *domestic partner - not a legal tax dependent*.

Federal regulations mandate that the value of providing health care benefits (medical, dental, etc.) to a domestic partner who is not your legal tax dependent be considered taxable income to you. P&G will use P&G's total cost for single coverage, minus the employee premium for single coverage to determine a net amount to be used for imputed income. The net amount is calculated annually and adjusted every January 1. The imputed income will appear on your paycheck on the same frequency as does your health care premium.

Example:

To calculate the imputed income amount for adding a domestic partner - not a legal tax dependent, assume for this example that the total cost of providing P&G health care benefits to a single individual is $165 per month, of which the employee pays $25 and the Company contributes $140. The value of that Company contribution ($140) is considered imputed income on which you are required to pay taxes.

	Single Rate
P&G's Total Monthly Cost to Carrier (referred to as "Working Rates") is comprised of the Employee Premium + Company Contributions	$165
Less Total Monthly Employee Premiums	$25
Total Monthly Company Contribution	$140

When Coverage Begins/Ends

When Coverage Begins

Initial Employee Eligibility for U.S. Health Care Benefits (i.e., New Hire, International Transfer, etc.)

- Employees are expected to enroll within 30* days of initial eligibility event.
- Employees are covered from your date of hire or transfer after you enroll in a health care plan, provided you enroll during the calendar year of your initial eligibility event. This is a retrospective process and can greatly affect how services and claims are handled in the health care plans. Special temporary coverage options apply to those transferring but whose families remain in the transfer location. If you are not actively at work on the day coverage is scheduled to begin, due to reasons other than illness or injury, coverage begins when you return to work.
- Coverage for an eligible spouse, children, domestic partner and household dependent(s) starts when your coverage takes effect.
- If you wait to enroll beyond the 30 day enrollment period and after the end of a calendar year (if after the 30 day enrollment period), you will be treated as having waived coverage and will have to wait until the next Annual Enrollment period for an effective coverage date of the next Plan year.
- If you enroll after the 30 day enrollment window, retroactive premiums will be collected after-tax.

Annual Enrollment

- If you had waived coverage for yourself (or any eligible dependent), you may enroll yourself (or any eligible dependent) during the Annual Enrollment period, with an effective coverage date of the beginning of the next Plan year.

Special Enrollment Situations (Mid-Year Enrollment Changes)

- **Adding a Newly Eligible Dependent** - If you get married or have a new child through birth, adoption, legal custody or marriage (stepchildren), the new family member (as well as yourself and any otherwise eligible dependents not already enrolled) will be covered on the day of the eligibility event if you enroll them within 30* days of that eligibility date (90* days for newborns). If enrolled after 30 days of their eligibility date, coverage will begin the day of enrollment by the Employee Service Center, as long as the enrollment occurs within the same calendar year. Any retroactive premiums will be collected after-tax. **Note:**
  - Newborn adoptions will be covered from their date of birth, rather than their date of adoption, when legal intent is established prior to birth. In other cases of adoption, guardianship, etc., coverage begins when the child is "legally placed" (i.e., the employee is legally the parent or guardian) when enrolled within 30* days of placement.
  - Newly eligible household dependents, domestic partners or children over age 18 becoming eligible can only enroll during the Annual Enrollment period.

  - In the event an employee divorces/drops a domestic partner who was covered by P&G's Healthcare Plan and the employee marries within the same month and wants to add the new spouse to the P&G Healthcare Plan, the former spouse/domestic partner will remain covered by applicable healthcare coverage through the end of the month of divorce/termination of domestic partner relationship, and the new spouse will not be covered until the first day of the month following the marriage date.

- **Adding a Newly Eligible Household Dependent Due To Birth** - If you have a newly eligible household dependent through birth, adoption or legal custody, the new household dependent will be covered on the day of the eligibility event if you enroll them within 30* days of that eligibility date (90* days for newborns). If enrolled after 30* days of their eligibility date (90* days for newborns), coverage will begin the day of enrollment by the Employee Service Center as long as enrollment occurs within the same calendar year. Any retroactive premiums will be collected after-tax.
- **Dependent child turning Household Dependent** - A dependent child turning age 25, who is also eligible as a household dependent, may continue coverage as a household dependent if you file an Affidavit of Household Dependent and enroll them within 30* days of their 25th birthday. Coverage as a household dependent begins on the first of the month following the month of their 25th birthday. If they are not enrolled within the 30 day enrollment period, coverage as a dependent child ends at the end of the month in which the event occurs and enrollment as an eligible household dependent can only be conducted during the Annual Enrollment period.
- **Loss of Health Care Coverage** - An otherwise eligible employee or dependent who had previously waived coverage, may enroll in the P&G Plan if they involuntarily lose coverage under a non-P&G health care plan. Enrollment must be within 30* days of the loss date for an effective date of the event. The individual must provide evidence of loss of coverage due to plan ineligibility or termination of contributions by an employer. If enrollment does not occur within the 30 day period, enrollment can only be conducted during the Annual Enrollment period for an effective coverage date of the next Plan year.
- **Dependent Change in Employment** - An otherwise eligible dependent who had previously waived coverage, may enroll in the P&G Plan if they lose coverage as a result of a change or loss of employment. The enrollment must be consistent with benefit changes that resulted from the change or loss of employment. Enrollment must be within 30* days of the employment change date for an effective date of the event. The individual must provide evidence of change or loss of employment. If enrollment does not occur within the 30 day period, enrollment can only be conducted during the Annual Enrollment period for an effective coverage date of the next Plan year.
- **Employee Change in Employment Status (i.e., Part time to full time, LOA to full time, etc.)** - An employee who has previously waived coverage for themselves and/or their eligible dependents, may enroll themselves and/or their eligible dependents if they have an employment status change that allows them to enroll mid year. Enrollment must be within 30* days of the employment status change for an effective coverage date of the event. If enrollment does not occur within the 30 day period, enrollment can only be conducted during the Annual Enrollment period for an effective coverage date of the next Plan year.

If you previously worked for P&G and were rehired, your coverage under our health care plans will start when you return to work.

*** Fully insured health care plans operate according to the carrier's rules. Employees enrolling in these plans (Hawaii residents only) should contact the carrier for information.**

When Coverage Ends

Coverage for Employees

Except as noted below, your health care plan coverages will end on the earliest of:

- the end of the month in which your employment ends for any reason (In case of retirement, other health care coverage may be available);
- the end of the month in which you become ineligible for health care plan benefits because of a change in your employment status;
- December 31, if you waive coverage during Annual Enrollment for the next Plan year;
- the end of the month in which you voluntarily withdraw from the Plan (waive coverage) as a result of a special disenrollment situation (see below);
- the date you die (see below);
- the date your Plan or group policy ends, terminates, or is changed to end coverage for the class to which you belong; or
- the end of the month in which any required employee contribution is not made.

Coverage for a Spouse, Children, Domestic Partner and Household Dependents

Except as noted below, the health care plan coverages for your spouse, children, domestic partner or household dependent(s) will end on the earliest of:

- the end of the month in which your coverage ends for any reason except death (If you die, your covered, eligible dependents may be eligible to continue coverage for 12 months after your death); or
- the end of the month in which a dependent becomes ineligible for your Plan as a result of:
    - a spouse becoming ineligible because of divorce, legal separation or annulment;
    - a child becoming ineligible because he or she marries, no longer depends on you for more than one-half of his or her support over 18, or reaches 25 (and is not eligible for continued coverage as a result of being physically or mentally handicapped);
    - a domestic partner or household dependent(s) becoming ineligible for your plans because you determined they will not meet one or more of the calendar year requirements;
    - the date a dependent becomes ineligible due to death;
    - December 31, if you waive your dependent's coverage during Annual Enrollment for the next Plan year; or
    - the end of the month in which you voluntarily withdraw a dependent from the Plan (waive coverage) as a result of a special disenrollment situation (see below).

Eligibility for all domestic partners and/or household dependents is determined on a calendar-year basis. He or she is eligible to be enrolled only during a calendar year when all eligibility requirements are met for the **entire calendar year**. If you enroll a person as a domestic partner and/or household dependent who, during that year, no longer meets the eligibility requirements, he or she must be disenrolled **within 30 days** of becoming ineligible. Federal regulations require that *imputed income* be assessed if you remove a domestic partner - legal tax dependent and/or household dependent from your health care coverage because he or she no longer meets the eligibility requirements for that calendar year. Please also see the Domestic Partner and Household Dependent Eligibility rules for more information regarding specific eligibility and enrollment requirements that apply to these groups.

Special Disenrollment Situations (Mid-Year Disenrollment)

- **Gain of Health Care Coverage** - You may voluntarily withdraw yourself and/or dependents from P&G coverage if you or they gain coverage under a non-P&G health care plan. The individual or individuals must provide evidence of gain of coverage. You must withdraw coverage within 30 days of the effective date coverage was gained. P&G coverage will end on the last day of the month in which the new coverage was effective. If coverage is not waived within the 30 day period, waiving coverage can only be conducted during the Annual Enrollment period for an effective coverage date of the next plan year.
- **Dependent Change in Employment** - You may voluntarily withdraw an enrolled dependent if they obtain other coverage as a result of a change or gain of employment. You must provide evidence of change or gain of employment. You must withdraw them within 30 days of the change or gain of employment. P&G coverage will end on the last day of the month in which the change or gain of employment was effective. If you do not withdraw them within the 30 day period, withdrawal can only be conducted during the Annual Enrollment period for an effective coverage date of the next plan year.
- **Employee Change in Employment Status (i.e., Full-Time to Part-Time, Full-Time to LOA, etc.)** - An enrolled employee may waive health care coverage for themselves and/or their eligible dependents if they have an employment status change that allows them to drop coverage mid-year. You must withdraw within 30 days of the employment status change. If coverage is not waived within the 30 day period, dropping coverage can only be conducted during the Annual Enrollment period for an effective coverage date of the next plan year.

There are times when your health care plans may continue even if you're not actively at work:

- **Leave of Absence** - Your health care plans may continue during approved leaves of absence with the Company paying its share of the cost through the third month after the month which includes your last day worked. Beyond this point, if you're not seeking an MBA Degree, P&G may allow you to continue your Healthcare Plan if you agree to assume the full cost of coverage. Check with the *Employee Service Center* before an absence starts for details on how your coverage will be affected.
    - **MBA Leave of Absence** - The Company health care plans will continue through the month of your last day worked. The employee may continue Company health care coverage through COBRA, normally 18 months, totally at their expense.
    - **Layoff** - If you work at a plant, mill, or office where operation is seasonal and you're temporarily laid-off, you may be eligible to continue your health care coverage. Check with the Employee Service Center for details on the availability and cost of continued coverage.
    - **Disability/Long Term Disability** - You'll qualify as disabled if you can't perform any job or work for pay or profit. If you qualify, your health care plans will continue with the Company paying its share of the cost for the first 104 weeks of disability. Your contribution will be waived in any month in which you do not receive salary payments. If you have at least 10 years of service as of the initial date of your disability, at the end of 104 weeks of disability, your health care plans will continue on the same basis until the end of your disability or until your employment ends. If you have less than 10 years of service as of the initial date of your disability, at the end of 104 weeks of disability, you may continue your health care plans by paying the full cost of the coverages. At least once per year you may be asked to provide satisfactory proof that you continue to qualify as disabled.

Continued Coverage At Termination of P&G Coverage

- **COBRA** - If your health care coverage ends due to termination or being ineligible due to employment status and/or your eligible dependents lose coverage due to your death or loss of eligibility, you and your dependents may be eligible to continue coverage under COBRA. COBRA continuation coverage rights are outlined in the Administration section of this plan. Although a domestic partner or household dependent(s) does not have rights to continuing COBRA coverage under existing Federal regulations, P&G offers continuation of coverage in certain cases. Continuation of coverage generally follows the same rules as COBRA as outlined in the Administration section of this Plan.

If You Die

If you die while an active employee, health care coverage for your spouse, children, domestic partner or household dependent(s) will continue for 12 months.

If you were eligible to retire at the time of your death, your spouse or domestic partner may continue coverage for himself or herself after 12 months by paying the full cost of the coverage in the National Surviving Spouse program. Contact the Employee Service Center for more details.

Health Insurance Portability and Accountability Act (HIPAA)

The **Health Insurance Portability and Accountability Act** (HIPAA) is a federal law which enables you and your dependents with certain medical conditions to obtain health coverage from a new employer or from a private health insurance company through limits on pre-existing condition exclusions.

If you and your dependents are enrolled in any P&G Medical Plan and lose coverage for any reason, you will be issued a certificate which states how long you were continuously covered under Procter & Gamble health plans. The amount of your continuous coverage under a previous health plan will reduce the **pre-existing condition** restriction period under your new plan.

Your previous health plan coverage, whether through Procter & Gamble or another health plan, is referred to as "creditable coverage" under HIPAA. In order for your creditable coverage to reduce a new plan's pre-existing condition exclusion period, you must not go more than 63 days without any medical coverage. Your certificate will be unnecessary once you are covered under a new plan for 18 months.

If you have a question about a certificate sent to you by the Company, you should contact the *HIPAA Administrator*.

If you have a certificate from a previous employer, keep it in a safe place in case you need it in the future. You do not have to give it to anyone at Procter & Gamble since our medical plans do not have pre-existing condition restrictions.

Definition of Pre-Existing Conditions Under HIPAA

The following is a basic definition of pre-existing conditions under HIPAA. **Procter & Gamble plans DO NOT have pre-existing condition exclusions.**

A **Pre-Existing Condition Exclusion** is defined as any limitation or exclusion of benefits based on a health condition that existed before the first day of coverage under the plan, whether or not any medical advice, diagnosis, care, or treatment was received before that day.

Under HIPAA, health plans can have a pre-existing condition restriction for a maximum of **12 months**, provided that you enroll within the initial eligibility period. If you enroll after your initial eligibility period, the restriction may be up to a maximum of **18 months**.

- For example, if you had heart surgery two months before starting coverage under your new health plan, and enrolled when first eligible, services related to that surgery could be excluded from coverage for up to 12 months.

However, under the HIPAA rules, that restriction period is **reduced** by the amount of continuous coverage you had previously either through Procter & Gamble or another health plan.

- For example, if your new health plan has a pre-existing condition restriction of 12 months and you had 12 or more months of continuous coverage under your previous health plan, your new health plan must make a determination based on your certificate, regarding your creditable coverage and the length of any pre-existing condition exclusion that applies to you.

Note:
The certificate expires after 24 months from the health care end date. If at any time there is a break in coverage of **63 days or more**, the full pre-existing condition limitation allowed by the plan will be imposed.

When Coverage Ends - Retirement

Regular Retiree

Coverage under this Plan will be in effect through the end of the month in which you retire.

Special Retiree (retired under terms of a Special Separation Agreement)

Current coverage and current payments will be extended through the end of the month of your retirement, plus the number of months outlined in your Agreement, unless you waive the extension of benefits coverage. These extra months beyond your retirement date will be administered by Procter & Gamble and its designated third party administrator or agent. You will receive a letter shortly after your retirement providing additional details about your extension of health care benefits and payment instructions. Invoices for the period of your extension of benefits will be sent to you by P&G's Healthcare Premium administrator. It is your responsibility to send in payments to continue coverage for your extended months of coverage. (NOTE: Monthly premium payments may change if premiums for active employees change.)

You are eligible to enroll in the P&G Retiree Plan effective the first month following the end of your extended coverage. If it is to your benefit to go into the P&G Retiree Plan sooner, you may waive the continuation of active coverage.

Employees who are not enrolled in healthcare coverage at the time of termination/retirement with a Special Separation Agreement are not eligible to enroll in active healthcare coverage for the extension of benefits period.

Administration

Benefit Funding

Our benefit plans are funded as follows:

Medical Plan

You currently pay part of the cost of coverage in the Plan. The money paid for coverage goes into The Procter & Gamble Benefit Plan Trust and is managed by the Trustees of this fund. In addition, we pay the full cost of a fund that could be used for employee severance pay if necessary and at the discretion of the Company. This fund is also held by The Procter & Gamble Benefit Plan Trust and may be used to pay medical expenses. Retiree medical plan costs are shared between the Company and the retiree. The retiree's share can change periodically. Benefits are paid by contract with the appropriate insurance carrier.

Dental Plan

We pay the full cost of your coverage if you're a full-time employee. Part-time employees are not eligible for dental benefits. Retiree dental plan costs are shared between the Company and the retiree. The retiree share can change periodically. Benefits are paid by contract with the insurance carrier. The money we pay for this coverage goes into The Procter & Gamble Benefit Plan Trust and is managed by the Trustees of this fund.

Legal Service

The agent for service of legal processes for benefit Plans is Ms. J.J. Ting, The Procter & Gamble Company, Two Procter & Gamble Plaza, Cincinnati, OH 45202, 513.983.1067. Legal process also may be served on a Plan trustee(s) or Policy Committee member(s) of any Plan (if applicable).

The Plan Carriers have been hired to process claims under the Plan. The Plan Carrier does not serve as an insurer, but merely as a claims processor. Claims for benefits are sent to the Plan Carrier. It processes the claims, then requests and receives funds from us to pay the claims, and makes payment on the claims to hospitals and other providers.

The Procter & Gamble Company is ultimately responsible for providing plan benefits, and not the Plan Carriers. The Procter & Gamble Company and the Plan Carriers share responsibility for administering the plan, as discussed in this Summary Plan Description.

COBRA

COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law under which employees and dependents are entitled to continue the same health care coverage as was provided before a qualifying event for a specific, limited period of time. For current information regarding applicable COBRA subsidy information due to The American Recovery and Reinvestment Act of 2009 (ARRA) and subsequent amendments and regulations for certain qualified assistance eligible individuals who were involuntary terminated from employment, please see your COBRA notice.

Although a domestic partner and his or her dependent children and your household dependents do not have rights to COBRA coverage under existing federal law, P&G offers continuation of coverage in certain cases.

Coverage Information

The coverage you receive under COBRA is a temporary **continuation** of the same health care coverage as was provided under Procter & Gamble's plans before the qualifying event. Provided you elect COBRA within the required time frames and pay the premiums as required:

- you and your covered dependents are entitled to up to 18 months of continuation coverage in the event of:
  - your termination of employment (for reasons other than gross misconduct);
  - retirement;
  - layoff;
  - reduced work hours; or
  - leave of absence.
- your dependents are entitled to up to 36 months of continuation coverage in the event of losing eligibility through:
  - your divorce/legal separation;
  - your death;
  - your dependent ceasing to be an eligible dependent; or
  - you becoming entitled to Medicare.

Employee's Responsibility to Notify P&G of a Qualifying Event

In the event of the qualifying events of divorce/legal separation of employee and spouse or a dependent's losing eligibility for coverage, you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notification orally or in writing to Procter & Gamble, *Employee Service Center*. You must provide your name, employee ID or Social Security number, type of qualifying event, and the date of qualifying event. You will be required to complete additional documentation to confirm this qualifying event. Refer to the appropriate section of the P&G intranet for complete instructions on what must be done to confirm this qualifying event.

If notification is not received within the specified notification time limits, your dependents who are losing eligibility for coverage may not be able to elect COBRA continuation coverage.

Note:
It is also a qualifying event if the employer undergoes a bankruptcy proceeding under Title 11 of the United States Code, with respect to covered employees who have retired.

If you or your dependent have more than one qualifying event, you or your dependent may receive up to a total of 36 months of continuation coverage, provided the second event occurred during the first continuation period. The 36-month period begins as of the date of the first qualifying event.

For example, if you continued family coverage for **18 months** because of your termination of employment and during that time you were divorced, your spouse would be entitled to COBRA continuation coverage for up to **36 months** from the date you terminated employment.

Under no circumstance would COBRA continuation coverage be available for more than 36 months.

You can change COBRA coverages by following the same rules that apply to active employees. For specific information about changing plan coverages, refer to the individual plans.

Disability Extension

If you, or your covered dependent, are determined by the Social Security Administration to be disabled at the time you lose eligibility under the Plan due to a qualifying event, or one of you becomes disabled during the first 60 days of continuing coverage, there is a special COBRA continuation period available.

Everyone who has continued coverage for 18 months may be eligible for an 11-month extension, for a total coverage continuation period of 29 months.

The 11-month maximum disability extension is granted if:

- the Social Security Administration makes a determination of disability;
- the disability started before the 60th day of COBRA coverage;
- the disability will last at least until the end of the 18-month period of continuation coverage; and
- the disabled individual notifies the *COBRA Administrator* within 60 days of the date of the determination and before the end of the first 18 months of the COBRA coverage period.

Cost/Contribution

Your out-of-pocket costs for COBRA continuation coverage are equal to the full cost of group coverage, plus a 2% administration fee. Full cost means your prior contribution plus any share paid by Procter & Gamble. You will see your actual costs when you receive your COBRA notification.

Note:
If you are continuing COBRA under a disability extension, the cost for COBRA continuation coverage during the first 18 months is the same as for all other persons continuing coverage under COBRA -- 102% of the full cost. During the 11-month disability extension (months 19 through 29 of coverage), the cost is 150% of the full cost, rather than 102%.

For current COBRA rates, refer to the Cost/Contribution page in each plan. If you need additional information, contact the COBRA Administrator.

When COBRA is elected, the COBRA Administrator will bill you directly on a monthly basis. When making premium payments for COBRA continuation coverage, a check payable to the COBRA Administrator, together with the bill, must be sent to the COBRA Administrator in time to be received by the payment due date.

The first COBRA payment is due **within 45 days** of the date COBRA continuation coverage is elected. The first payment must be retroactive to the day coverage under Procter & Gamble's plan was lost. Coverage is not active until payment is received.

Thereafter, premium payments must be submitted by the first of the month for which continuing coverage is desired. For example, the premium payment for July would be due by July 1.

Contributions for all COBRA coverages are combined into one payment. Separate payments are not required for each type of coverage elected. If you do not pay the required premiums, you will be disenrolled.

In the case of a Special Separation, the employee continues to pay active employee premiums for an agreed upon time, as defined in the Special Separation Agreement. Coverage during the Special Separation period is administered by the Employee Service Center. You will receive a Special Separation form. The active employee premium rates are reflected on the Special Separation form and apply during the Special Separation period. The Special Separation period does not count as COBRA (certain acquired company's employees will be handled according to their former company rules, so special circumstances may apply).

COBRA begins after the Special Separation period and may continue for 18 months. You will receive a Notification of Continuation of Coverage COBRA form from the Employee Service Center approximately two months prior to the end of the Special Separation period of coverage. The COBRA rates are listed on the COBRA form next to the appropriate Health Care plan and are valid at the end of the Special Separation period. Coverage during the COBRA period is administered by SHPS.

Eligibility

COBRA continuation coverage may be available to you and/or your dependent(s) if coverage was lost by becoming ineligible for medical or dental under the Procter & Gamble plans because of a qualifying event. However, if you and/or your dependent(s), become covered by Medicare or another group health plan after electing COBRA, the COBRA coverage will end.

If you, or your dependent(s), are covered by a group plan that has a pre-existing condition limitation that affects you, you may continue coverage under COBRA until the **earlier** of:

- the date the pre-existing limitation no longer affects you; or
- the date coverage would end according to the COBRA rules, whichever occurs first.

Eligible dependents covered at the time of the qualifying event have an independent right to COBRA, whether or not you are eligible to elect COBRA. A dependent that becomes eligible and enrolls during the COBRA continuation period does not have any independent rights to COBRA (including loss of eligibility during the continuation period).

How long COBRA may continue will depend on the qualifying event that made you or your dependent eligible for COBRA coverage.

Claims

Expenses which were applied to any deductible, out-of-pocket or annual maximum under your medical or dental plan carry over to COBRA coverage during the same plan year.

Under COBRA continuation coverage, there is no change in the way you file claims. Continue to file your claims with each claims administrator in the same way you always have. Claim forms may be obtained from your health care plan carrier.

If your claim is denied, you should call the claims administrator of the individual plan to determine the reason. If you disagree, you may appeal.

Appeals

Your coverage under COBRA is a continuation of coverage you had under P&G-sponsored benefit plans. Therefore, you may appeal a denied or reduced claim by following the rules and procedures that pertain to each individual plan.

If you believe that your claim for benefits under COBRA continuing coverage has been unfairly denied or reduced, you should contact the Appeals Department for that Plan.

Continue Group Health Plan Coverage

Your continuing coverage in P&G plans, including COBRA continuation coverage, counts as creditable coverage for other employer plans. This may reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your new group health plan. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. You should be provided a certificate of creditable coverage, free of charge, from P&G when you lose coverage either under the plan, or under COBRA continuation coverage.

ERISA Rights

As a participant in the P&G Healthcare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, if applicable, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available from Public Disclosure at the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator's office and at other specified locations, such as worksites and union hall, all documents governing the plan, including insurance contracts and collective bargaining, if applicable and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available from Public Disclosure at the Pension and Welfare Benefit Administration.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. The people who operate your plan, called "Fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and the other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5625, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Future of Plans

Although we expect to continue the benefit Plans described in this document indefinitely, the Procter & Gamble Company, acting through its Board of Directors or Global Human Resources Officer, reserves the right to alter, amend or terminate any Plan. If the Board of Directors alters, amends or terminates the Plan, it shall be through formal action either at a Board of Directors meeting or by written consent pursuant to state law. Alternatively, the Global Human Resources Officer may modify or terminate the Plan by signing a formal written statement of the alteration, amendment or termination.

If a Plan is terminated and isn't replaced by similar coverage, you'll be told of any conversion rights that may apply.

HIPAA Privacy Notice

Effective 4/14/2003

This Notice of privacy practices has been drafted to be consistent with what is known as the "HIPAA (the Health Insurance Portability and Accountability Act of 1996) Privacy Rule". We are required by law to provide you with this Notice and to comply with this Notice.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Protecting medical information about you is important. This notice applies to all of the records of your care generated under The Procter & Gamble Health Care Plans, whether made by health care professionals or other personnel.

This notice describes the type of information we might gather about you, with whom that information may be shared according to the HIPAA Privacy Rule and the safeguards we have in place to protect it. Generally, we receive only summary health information or information concerning plan enrollment or eligibility from the third party administrators or your insurance carriers. In addition, we may provide benefits through a health insurance issuer or health maintenance organization ("HMO"). The health insurance issuer or HMO may have its own policies and notice regarding your health information. You should review those notices for information about how the insurance issuer or HMO will handle your medical information in their possession.

You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when the release is required by law. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Maintain the privacy of your personal medical information;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Who Will Follow This Notice

This notice describes The Procter & Gamble Health Care Plans' practices regarding the use of your medical information for treatment, payment or health care purposes described in this notice. All employees, staff and other personnel who may need access to your information follow the terms of this notice.

How We May Use and Disclose Medical Information About You, According to the HIPAA Privacy Rule

The following categories describe different ways that our health care plans (or the third party administrators or the insurance carriers) may use and disclose medical information. Not every use or disclosure in a category will be listed.

For Treatment. The health care professionals may use medical information about you to provide you with medical treatment or services. The medical information about you may be disclosed to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you. Different health care professionals also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. In addition, your medical information may be used or disclosed to obtain prior approval or to determine whether the treatment is covered under the Plan.

For Health Care Operations. We may use and disclose medical information about you for health care quality control and benefit evaluation. This is necessary to make sure that all of our participants receive quality care. For example, we may use medical information to review and evaluate the services you received. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific persons are.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special Situations, According to the HIPAA Privacy Rule

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose medical information about you in response to a subpoena, discovery request, or other lawful order from a court.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information about you:

Right to Access. You have the right to review and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

You should directly contact the third party administrator or your insurance carrier hired by the Plans to request a copy or an inspection of your medical file. Your health care providers, not the Plan, maintain your medical information. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to your health care providers, the third party administrators or your insurance carrier. If you request a copy of the information, a fee may be charged for the costs of copying, mailing or other supplies associated with your request.

Your request to inspect and copy may be denied in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request.

Right to Amend. If you feel that medical information about you is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment for as long as the information is kept.

To request an amendment, your request must be made in writing and submitted to the third party administrator or your insurance carrier listed in the Summary Plan Descriptions. In addition, you must provide a reason that supports your request.

Your request for an amendment may be denied if it is not in writing or does not include a reason to support the request. In addition, your request may be denied if you ask to amend information that:

- was not created by the Procter & Gamble Health Care Plans;
- is not part of the medical information kept by The Procter & Gamble Health Care Plans;

- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" for instances in which we or our third party administrator disclosed your personal and health information for purposes other than treatment, payment, health care operation and certain other activities. To request this list or accounting of disclosures, you must submit your request in writing to our third party administrator or your health care providers. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. You may be charged for the costs of providing the list.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the third party administrator or your insurance carrier. In your request, you must state (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. You must state that the information could endanger you if it is not communicated in confidence. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time. To obtain a paper copy of this notice, please request one in writing from the *Employee Service Center*.

Changes To This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Procter & Gamble Health Care Plan at:

Active HealthCare Benefits Managers
The Procter & Gamble Company
2 Procter & Gamble Plaza, TE-3
Cincinnati, OH 45202

If you are an active employee, you also may file a complaint with your immediate manager or the Human Resources contact for your site or organization. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to protect the privacy of your personal and health information.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Privacy Officer

The Global Privacy Executive of the Procter & Gamble Company assumes the role of the HIPAA Privacy officer.

Contact Information:

To request a paper copy of this Privacy Notice, contact the *Employee Service Center*.

To contact your third party administrator or your insurance carrier, please refer to the Summary Plan Descriptions for that information. If you are an active employee, you may also refer to the Benefits Resources List, on the P&G intranet.

HIPAA Privacy Rule Compliance

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Procter & Gamble Group Healthcare Plan ("Plan") may disclose Summary Health Information to the Plan Sponsor (The Procter & Gamble Company), if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.536);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department on Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further use and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(ii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii), is established as follows:

> i. The following employees, or classes for employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed: Benefit Managers and staffs, Site benefit personnel, Plan Auditor and any employee or person who receives PHI relating to payment under, health care operations of, or other matters pertaining to, the Plan in the ordinary course of business.
> ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
> iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.
> "Plan Administration" activities are limited to activities that would meet the definition of payment of health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-outs plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(l)(iii) of the Privacy Standards (45 CFR 164.504(f)(l)(iii), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator of the third party administrator or claims administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefits claims under the Plan. Such disclosures shall be made in accordance with Privacy Standards.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with Privacy Standards.

Children's Health Insurance Program Reauthorization Act of 2009

Eligible employees and participants have a "Special Enrollment Right" under the Healthcare Plan that allows certain eligible but un-enrolled employees and participants to enroll in a Benefit Plan Option that is group health plan if the dependent child or employee: (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (3) becomes eligible for group health plan premium assistance under Medicaid or SCHIP. The eligible employee or participant must request an election change to enroll in group health plan coverage within 60 days from the date (1) the coverage terminates under the Medicaid or SCHIP plan or (2) the employee or dependent child is determined eligible for state premium assistance.

If you believe you are eligible for a Special Enrollment, you must contact the Employee Service Center to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by the Employee Service Center. Requests for a Special Enrollment right must be made within 60 days of an event described above that occurs on or after April 1, 2009.

Plan Identification

Official Plan Name:

The Procter & Gamble Health Care Plan

Plan Number:

503

Effective Date:

January 1, 2010

Plan Year:

For Plan operation including but not limited to all coverage limitations, coordination of benefits and co-insurance: Jan 1 thru Dec 31

For 5500 filing purpose: June 30 thru July 1

Type of Plan:

Welfare Plan providing health care insurance for medical, dental, EAP, prescription medication and organ transplant services.

Type of Administration:

The Company shares responsibility with the insurance companies for administering these program benefits.

Contract Participants (as applicable for each site/group):

Anthem Blue Cross and Blue Shield (Medical Provider)
P.O. Box 33200
Louisville, KY 40232-3200

Caremark (Prescription Medications)
9501 E. Shea Blvd.
Phoenix, AZ 85260-6719

Concern Plus (EAP Provider)
11121 Kenwood Rd.
Cincinnati, OH 45242

Employee Network Inc. (EAP)
1040 Vestal Parkway East
Vestal, New York 13850

Humana (Medical Provider)
500 W. Main Street
Louisville, KY 40202

UnitedHealthcare (Medical Provider)
450 Columbus Blvd.
Hartford, CT 06103

UnitedHealthcare (Prescription Medications)
450 Columbus Blvd.
Hartford, CT 06103

UnitedBehavioral Health Solutions (EAP Provider)
425 Market Street, 14th Floor
San Francisco, CA 94105

The Procter & Gamble Company and its subsidiaries
EIN: 31-0411980

The Procter & Gamble Company Benefit Plan Trust
Two Procter & Gamble Plaza
Cincinnati, OH 45202

1.888.627.7472

Employer/Sponsor:

The Procter & Gamble Company and its subsidiaries
EIN# 31-0411980

The Procter & Gamble Company and its subsidiaries
Two Procter & Gamble Plaza
Cincinnati, Ohio 45202

Plan Administrator:
The responsibility for Plan Administration is delegated to the Health and Welfare Committee. The current Committee members are:

J.G. Hagopian;
D.A. Tiersch
and Dean Wunderle

BUSINESS ADDRESS
Two Procter & Gamble Plaza
Cincinnati, Ohio 45202

Plan Trustees/Committee

BUSINESS ADDRESS OF EACH TRUSTEE/COMMITTEE MEMBER

The address of **all** Trustees is:
Two Procter & Gamble Plaza, Cincinnati, Ohio 45202.

THE PROCTER & GAMBLE BENEFIT PLAN TRUST/COMMITTE (HEALTH CARE PLANS)

Committee members:

D.A. Tiersch, Director, H.R. Finance, N.A.

J.G. Hagopian, Director, H.R. Product Supply, N.A.

D.J. Wunderle, Associate Director, H.R., MDO, N.A.

Plan Sponsor/Employer:
The Procter & Gamble Company and its subsidiaries
EIN: 31-0411980

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Cincinnati, OH 45202

1.888.627.7472

Glossary

Actively at Work

"Actively at work" means that you (the employee) are regularly working your full number of hours at your full rate of pay and at your regular place of employment.

If you were actively at work, as just defined, on your last regular working day, then you are considered to be actively at work:

- on Company holidays; and
- on each day of a paid vacation.

However, you are not actively at work while on an unpaid leave of absence.

Affidavit of Domestic Partner

An Affidavit is a sworn statement in writing that you and your domestic partner attest to a series of statements that establish your relationship and accept agreed terms.

There are two domestic partner affidavits; one for attesting a domestic partner relationship that does not qualify as an IRS dependent; and one that attests to a domestic partner relationship that does qualify as an IRS dependent.

What it Does ... Makes you eligible to enroll your domestic partner and your domestic partner's child(ren) in benefits.

What it Doesn't Do... Automatically enroll your domestic partner or his or her child(ren) in benefits. After carefully reading the appropriate Affidavit of Domestic Partnership, you and your domestic partner will need to provide the information requested on the form.

Eligibility Rules - Refer to the Eligibility > Domestic Partner section of the Plan for domestic partner eligibility details.

Enrollment Rules - Refer to the Procedures > Enrollment > Additional Enrollment Information - Domestic Partner and/or Household Dependent section of the Plan for domestic partner enrollment details.

Keep a copy of your signed form.

Affidavit of Household Dependent

An Affidavit is a sworn statement in writing that you and your household dependent attest to a series of statements that establish your relationship and accept agreed terms.

What it Does ... Makes you eligible to enroll your household dependent in benefits.

What it Doesn't Do... Automatically enroll your household dependent in benefits. After carefully reading the Affidavit of Household Dependent, you will need to provide the information requested on the form.

Eligibility Rules - Refer to the Eligibility > Household Dependent section of the Plan for domestic partner eligibility details.

Enrollment Rules - Refer to the Procedures > Enrollment > Additional Enrollment Information - Domestic Partner and/or Household Dependent section of the Plan for domestic partner enrollment details.

Keep a copy of your signed form.

After-Tax

After-tax, also referred to as post-tax, means that the cost of a benefit is deducted **after** taxes have already been calculated and taken out of gross income.

Allogeneic

Sufficiently different from the recipient.

Annual Enrollment

"Annual Enrollment" is the period of time each year when you can make or change coverage elections without a qualifying *Special Enrollment Situation*.

Coverage for elections made during Annual Enrollment begins on the first day of the new plan year.

Annual Enrollment for benefits generally occurs in the fall. You will be notified when it begins and ends.

Assignment

Assignment is the transfer of a claim, right, interest or property from one person to another person.

In health care plans, for example, when you assign a benefit, you authorize the insurance company to pay the physician or hospital directly, instead of sending the benefit check to you.

For life insurance, when you assign a benefit, you transfer the right to make contributions, to obtain an individual policy or to change the beneficiary, to another person.

Autologous

Derived from the same individual.

Behavioral Health

"Mental illness" means mental, nervous, stress-related or emotional diseases or disorders of any type.

Substance abuse, also referred to as chemical dependency, is the inappropriate use of a controlled substance which is any substance defined as such in Title 11 of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as it is now and as it may be amended.

Co-insurance

The term co-insurance refers to the percentage of covered expenses you are responsible to pay. For example, a co-insurance rate of 10% means that the Plan will pay 90% of covered expenses, and you are responsible for the remaining 10%. Plan-specific deductibles and out-of-pocket maximums may apply. Specific requirements may exist concerning deductibles and out-of-pocket maximums. Refer to the Benefit Amount (What's Covered) section of the plan for information concerning how co-pay, deductibles and out-of-pocket maximums may impact co-insurance.

Co-payment

A co-payment is the amount you pay before the Plan begins to pay benefits for specific covered services.

Covered Services/Charges

Covered services are those which are:

- reasonable and customary, or based on the fee schedule allowance amount as determined by the plan; and
- performed or prescribed by a doctor;
- rendered to a covered person for the treatment of injury or sickness; and
- medically necessary in terms of generally accepted medical standards.

Deductible

Your deductible is a portion of covered medical expenses (for medical plans) or dental expenses (for dental plans) you pay before the Plan pays benefits.

Domestic Partner - A Legal Tax Dependent

Procter & Gamble defines same or opposite sex domestic partners as two people in a spouse-like relationship who have met all of the following requirements for at least the last twelve (12) months:

- intend to remain each other's domestic partner indefinitely;
- reside together in the same permanent residence;
- neither of you are legally married or separated nor the domestic partner of anyone else;
- neither of you is related by blood to a degree of kinship that would prevent marriage under applicable law of the state where you reside;
- both are jointly responsible for each other's welfare and financial obligations, or, your domestic partner is chiefly dependent upon you for care and financial assistance; and
- both are at least eighteen (18) and are mentally competent to enter into a legal contract.

A roommate **can not** be a domestic partner.

In addition, a domestic partner - legal tax dependent must meet all the following requirements of a legal tax dependent:

Section 152 of the Internal Revenue Code says your domestic partner can be claimed as your legal tax dependent when you file your tax return for any year in which they meet all of the following criteria:

- reside in the United States or U.S. sovereign territories and is a U.S. citizen or permanent resident alien;
- receives more than one-half his or her support from you for the entire calendar year; and
- lives with you and is a member of your household for the entire year.

To be considered an eligible domestic partner, P&G must have an accepted *Affidavit of Domestic Partner* on file.

Domestic partners must be U.S. citizens or permanent residents. Individuals who are in the U.S. on long-term or temporary visas, such as work, student, tourist or medical visas, are not eligible for coverage (for purposes of U.S. healthcare eligibility, the individual must also reside in the United States or U.S. sovereign territories). You may be required to show documentation of domestic partner eligibility.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

For further details, refer to the Eligibility section of each Plan.

Domestic Partner - Not a Legal Tax Dependent

Procter & Gamble defines same or opposite sex domestic partners as two people in a spouse-like relationship who have met all of the following requirements for at least the last twelve (12) months:

- intend to remain each other's domestic partner indefinitely;
- reside together in the same permanent residence;
- neither of you are legally married or separated nor the domestic partner of anyone else;
- neither of you is related by blood to a degree of kinship that would prevent marriage under applicable law of the state where you reside;
- both are jointly responsible for each other's welfare and financial obligations, or, your domestic partner is chiefly dependent upon you for care and financial assistance; and
- both are at least eighteen (18) and are mentally competent to enter into a legal contract.

A roommate **can not** be a domestic partner.

A domestic partner who is not a legal tax dependent must meet all P&G-defined domestic partner eligibility requirements, but is not required to meet the Legal Tax Dependent criteria as defined in Section 152 of the Internal Revenue Code.

To be considered an eligible domestic partner, P&G must have an accepted *Affidavit of Domestic Partner* on file.

Domestic partners must be U.S. citizens or permanent residents. Individuals who are in the U.S. on long-term or temporary visas, such as work, student, tourist or medical visas, are not eligible for coverage (for purposes of U.S. healthcare eligibility, the individual must also reside in the United States or U.S. sovereign territories). You may be required to show documentation of domestic partner eligibility.

Failure to notify P&G within 30 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters that may subject an employee to disciplinary action up to and including termination of employment and/or legal action against employees or retirees. Any benefits paid by P&G for services rendered to a person may be recovered from the employee in full via payroll deduction or legal action, or the retiree in full via legal action, if the person was no longer eligible for coverage at the time the services were rendered, became ineligible, or the person was never eligible for coverage.

For further details, refer to the Eligibility section of each Plan.

Emergency Care

An emergency is a sudden, serious, unexpected, life-threatening illness or injury that requires immediate medical attention in a hospital emergency room. An emergency includes:

- accidental, traumatic bodily injury; and
- a serious life-threatening condition with severe symptoms which, if not immediately treated, could reasonably be expected to result in loss of life or permanent disability.

Some examples of conditions requiring emergency care are:

- severe bleeding;
- suspected heart attack;
- serious burns;
- severe stomach or chest pains;
- serious breathing difficulties;
- choking;
- poisoning;
- unconsciousness; and/or
- broken bones.

Experimental, Investigational or Unproven Care

Experimental, Investigational or Unproven Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, medication therapies or devices - that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use and not identified in either the American Hospital Formulary Service, or the United States Pharmacopeia Dispensing Information, as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

(For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

Explanation of Benefits (EOB)

An Explanation of Benefits, or EOB, is a statement issued by a claims administrator notifying you of claims processed on your behalf, with an explanation of how charges were handled.

Extended/Skilled Nursing Care Facility

Extended/Skilled Nursing Care Facility is an institution or a distinct part of an institution that has a transfer agreement with one or more hospitals, and that is engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care. The facility must:

- be accredited as an Extended or Skilled Nursing Care Facility by the Joint Commission on Accreditation of Hospitals, or is recognized as an Extended or Skilled Nursing Care Facility by Medicare;
- be supervised by one or more doctors and have one or more registered professional nurses responsible for the care of patients;
- have each patient under supervision of a physician;
- maintain clinical records on all patients;
- provide 24-hour nursing services;
- provide appropriate methods and procedures for the dispensing and administering of medications and biologicals;
- be duly licensed by the appropriate governmental authorities;
- not be, other than incidentally, a hotel, a motel, a place of rest, or place for custodial care, a facility for the aged or a facility for treatment of behavioral health diseases or substance abuse.

Pre-certification may be required. Refer to your Plan's Coverage Information chart for details.

Full-Time

Regular employees are those persons employed by the Company on a full-time basis in continuing positions authorized by the appropriate Vice President. Full-time means the standard workweek (generally 40 hours) as established at each location. Employees do not include any persons whose services are provided under an agreement between the Company and a temporary employment agency or similar person or organization. The Company will determine if a person is a full-time employee.

Generic Medication

A generic medication is a prescribed medicine that is chemically equivalent and has the equal standards of safety, efficacy and quality with the FDA as name brand medications but is not trademarked. Generic medications are available for many commonly prescribed medicines, usually at significantly lower costs.

Household Dependent

To qualify as a household dependent, an individual must meet **all** of the following requirements:

- be under age 65;
- be a U.S. citizen or permanent resident. Individuals who are in the U.S. on long-term or temporary visas, such as work, student, tourist, or medical visas, are not eligible for coverage (for purposes of U.S. healthcare eligibility, the individual must also reside in the United States or U.S. sovereign territories);
- receive more than one-half of his or her support from you for the calendar year;
- live in your household for the entire calendar year (except for temporary absences due to illness, education, business, vacations, military service or an indefinite stay in a nursing home).

Your housekeeper, maid, servant or other domestic employee who lives with you **can never** be your household dependent.

For more information, refer to the Eligibility section of each Plan.

Imputed Income

In accordance with the Internal Revenue Code, a portion of the value of certain coverage that must be reported as part of your gross taxable income is commonly referred to as imputed income. You will pay federal, FICA, state, local and other applicable payroll taxes on imputed income amounts. The additional taxable income is not included when calculating benefits or contributions under any plan based upon compensation (e.g., Profit Sharing, life insurance, disability benefits, etc.).

The Internal Revenue Service considers as imputed income, on which IRS regulations require income tax to be paid:

- the amount of Procter & Gamble's contribution toward a disenrolled domestic partner - legal tax dependent's and/or household dependent's health care premium;
- the amount of Procter & Gamble's contribution toward a domestic partner - not a legal tax dependent's health care premium; and
- the value of an employee's life insurance benefit over $50,000.

Imputed Income - Health Care - Disenrollment of Domestic Partner - Legal Tax Dependent and/or Household Dependent

Imputed income is based on the value of your health care coverage. The value of health care coverage is determined by using the Company's total monthly cost for single coverage (medical, dental, etc.), minus the employee premium for single coverage, multiplied by the number of months in the Plan year that the person was enrolled.

Imputed Income - Health Care - Domestic Partner - Not a Legal Tax Dependent

Federal regulations require the value of providing health care benefits (including medical, dental, etc.) to a domestic partner who is not a legal tax dependent be included as taxable income to you. This means you will pay federal, FICA, local, state and other applicable payroll taxes on an additional amount throughout the year and the Company will report it on your W-2 form at the end of the year. The value of health care is determined by using the Company's total monthly cost for single coverage (medical, dental, etc.), minus the employee premium for single coverage.

Imputed Income - Life Insurance

Imputed income is the value of any employer-provided life insurance benefit over $50,000. IRS regulations require you to pay income tax on this amount. The actual amount of imputed income is determined by IRS tables based on age.

In-Network

Care is considered to be in-network, also referred to as network, only if it is received from a network provider.

Less Than Full Time (LTFT)

Under the Company's Flexible Work Arrangement policies, full time employees may get approval to temporarily work a reduced schedule. These Less Than Full Time (LTFT) work schedules can only be established when they meet both the employee's personal needs and the organization's needs.

Medically Necessary/Medical Necessity

Health care services and supplies which are determined by the Plan administrator to be medically appropriate, and:

- necessary to meet the basic health or dental needs of the covered person;
- rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;
- consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care and dental coverage organizations or governmental agencies that are accepted by the Company;
- consistent with the diagnosis of the condition;
- required for reasons other than the comfort or convenience of the covered person or his or her physician or dentist; and
- demonstrated through prevailing peer-reviewed medical or dental literature to be either:
    - safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - safe with promising efficacy for treating a life-threatening sickness or condition in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness or pregnancy does not mean that it is medically necessary as defined. This definition relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary.

Network Physician/Provider

Network Providers are a select group of doctors, hospitals and other medical care providers who have joined the network. These doctors and other providers are given the opportunity to join the network in exchange for providing you with preferred fees and agreeing to medical treatment procedures that assure high quality, cost-effective care.

Pre-certification/Authorization

Pre-certification/Authorization is the process of contacting the Plan to provide information that a covered person is seeking a particular treatment or hospital admission. Some plans require that you actually obtain their confirmation that a service, supply, medication or treatment is medically necessary. Other plans simply require you to inform them before the treatment or admission occurs in order to obtain coverage information and/or provide information needed to administer a claim.

Certain network-only plans rely on network providers to initiate the pre-certification/authorization process. However, many plans hold the member responsible to contact the Plan for pre-certification/authorization.

Failure to follow the Plan's pre-certification/authorization requirements may result in a substantial reduction in benefits as described in the Procedures > Pre-certification/Authorization section of the Plan.

Out-of-Pocket Maximum for Medical Expenses

An out-of-pocket maximum limits the amount of money you must pay each plan year for you or your family's share of *covered expenses*.

Once you reach, or a dependent reaches the individual out-of-pocket maximum, the Plan will pay 100% of most of the eligible, covered expenses for that individual for the rest of the plan year. Once you reach the EE+1, EE+1/Family, or Family out-of-pocket maximum (as applicable at your site), the Plan will pay 100% of most of the eligible, covered expenses for you and your covered family members for the rest of the plan year.

Not all of your out-of-pocket expenses are applied to the out-of-pocket maximum. In addition to the items listed on your Plan's Coverage Information chart, premiums paid for health care coverage, charges above eligible amounts and penalties for not obtaining *pre-certification/authorization* are **excluded** from the out-of-pocket maximum. Further, any expenses the plan would not normally pay will continue to be your responsibility even after the out-of-pocket maximum has been reached.

Check your plan's Coverage Information Overview section to determine what is included in your out-of-pocket maximum.

Out-of-Network

Care is considered to be "out-of-network" if it is received from a provider who is not a member of the network.
Benefits for out-of-network care are paid at the lower out-of-network level. Refer to the Plan's Coverage Information Chart for details on out-of-network benefits.

Part-Time

Part-time employees are those persons employed by the Company specifically in a part-time position who are not intended to work a standard workweek. Part-time employees are normally planned for work schedules of 2 - 3 days per week (800 - 1,200 hours per year), and no more than 1,500 hours per year. A work schedule of 1,500 hours or more begins to approach a full-time employment arrangement. Schedules approaching 1,500 hours require special handling, in advance, and require approval from your local HR representative in addition to the US Employee Relations Center of Excellence.

Part-time employees do not include any person whose services are provided under an agreement between the Company and a temporary employment agency or similar person or organization.

Pre-Tax

Contributions which are pre-tax are taken from pay before Federal, Social Security, and in most cases, state and local taxes are deducted.

When you elect to make pre-tax contributions, you agree to have a part of your earnings deducted as contributions before reaching your paycheck, in effect reducing your taxable income. By reducing taxable income, less is owed in taxes; however, this may also reduce future Social Security benefits.

Primary Plan

When a person is covered under more than one plan, the plan that is responsible for processing claims for that individual **first** is the primary plan.

The plan, if any, responsible for processing claims for that individual **second**, is called the secondary plan.

Qualified Domestic Relations Order (QDRO)

A Qualified Domestic Relations Order (QDRO), is an order or judgment from a state court directing the Plan Administrator to pay all or a portion of a participant's Plan benefits to a former spouse or dependent.

A QDRO may, for example, direct that all or part of your benefits under the Pension Plan or 401(k) Savings Plan be applied to:

- child support;
- alimony payments; or
- a marital property settlement agreement.

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a state court order, decree or judgment that requires group health plans to provide health benefits to a plan participant's child.

Reasonable and Customary - Medical

Generally, a reasonable and customary medical charge is the amount determined by the Plan to be appropriate reimbursement for a covered expense.

A covered expense is considered to be a "reasonable and customary charge" when it is within established fees for similar treatment or services, provided by a doctor with similar training, for specific medical conditions in a particular geographic area.

The term "reasonable and customary" also refers to the length of treatment and type of care the person receives for a diagnosed condition, and whether it is appropriate to established medical practices.

Secondary Plan

When a person is covered under more than one plan, the plan that is responsible for processing claims for that individual **second** is the secondary plan.

The plan responsible for processing claims for that individual **first** is called the primary plan.

Special Enrollment Situations

A Special Enrollment Situation is an event that permits you to make certain changes to your benefit elections outside of *Annual Enrollment*. These situations are subject to Federal Regulations and may effect enrollment in:

- Flexible Benefit Options (i.e., Life Insurance, Spending Accounts, etc.);
- Disability Plan;
- P&G Health Care Plans (medical, dental, etc.).

The *Employee Service Center* will determine whether your requested change in coverage is consistent with the Special Enrollment Situation you have experienced.

Special Enrollment Situations can be broadly categorized as Start Employment Events, Work Status Change Events, Family Status Change Events, and Retirement Events. Refer to the Procedures > Enrollment section of each Plan for details.

If you are an employee eligible for domestic partner and/or household dependent benefits, be sure to review the Procedures > Enrollment > Additional Enrollment Information - Domestic Partner and/or Household Dependent page for specific details regarding enrollment.

Urgent Care

An urgent care situation is an unexpected episode of illness or injury requiring treatment that cannot reasonably be postponed for scheduled physician care, but does not require emergency room care. Some examples are:

abdominal pain;
abrasions;
acute sunburn;
animal and insect bites;
earache;
fever below 104 degrees;
minor burn;
minor cut/laceration;
persistent nausea and vomiting;
significant flu;
significant sore throat; and
significant sprain.

Contacts

Anthem Blue Cross and Blue Shield:

Phone and Hours:
1.800.968.9175 - Medical Claims/Customer Service
1.866.776.4793 - Pre-authorization Center
8:00 A.M. to 8:00 P.M. (EST), Monday - Friday

Website: *www.anthem.com*

Claims Address:
Anthem Blue Cross and Blue Shield Medical Provider
P.O. Box 37180
Louisville, KY 40223-7180

Appeals Address:
Anthem Blue Cross and Blue Shield
National Appeals
P. O. Box 33200
Louisville, KY 40232-3200

Caremark - Retail and Home Delivery Prescription Plan Information:

Phone and Hours:
1.800.474.5741 - Claims/Customer Service/Appeals - (Please follow voice prompts)
9:00 A.M. to 1 A.M. (EST), Monday - Friday
10:00 A.M. to 7:00 P.M. (EST), Saturday and Sunday

1.800.378.5697 - Physician calling in Home Delivery Prescription
9:00 A.M. to 5:30 P.M.(EST), Monday - Friday

1.888.413.2723 - Physician # for Prior Authorization Approval

1.800.378.0323 - Physician Home Delivery Fax

Website: *www.caremark.com*

Retail Prescriptions and Specialty Medication Pharmacy Services Claims Address:
CVS Caremark
P.O. Box 52162
Phoenix, AZ 85072-2162

Retail & Home Delivery Prescriptions Appeals Address:
CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072-2084

Home Delivery Prescriptions Claims Address (Mail Order Facility):
CVS Caremark
P.O. Box 830070
Birmingham, AL 35283-0700

For HIPAA related requests or concerns, please contact CVS Caremark in writing at:
CVS Caremark Privacy Office
P.O. Box 52136
Phoenix, Arizona 85072-2136

Caremark Specialty Pharmacy Services - CaremarkConnect:

Phone and Hours:
1.800.237.2767
1.800.323.2445 (Fax)
5:30 A.M. to 7:00 P.M. (Central Time), Monday - Friday

Specialty Claims Address:
CaremarkConnect
P.O. Box 52116
Phoenix, AZ 85072-2116

Specialty Appeals Address:
CaremarkConnect
Prescription Claim Appeals MC 109
P.O. Box 52084-2084
Phoenix, AZ 85072-2084

COBRA Administrator - SHPS

Phone:
1.800.301.7559

Hours:
8:00 A.M. to 6:00 P.M. eastern time, Monday - Friday

Address:
SHPS
P.O. Box 34640
Louisville, KY 40232-4640
Attention: P&G COBRA Unit

CONCERNPLUS - EAP and Work Life Services

Phone and Hours:
1.513.891.1691 or 1.800.642.9794 (emergency)
8:30 A.M. to 5:00 P.M. (EST), Monday - Friday
In an emergency, representatives are available: 24 hours a day, 7 days a week.

Claim Submission Address:
TriState Benefit Solutions
619 Oak Street
Cincinnati, OH 45206

Information and Appeals Address:
CONCERNPLUS
11121 Kenwood Rd.
Cincinnati, OH 45242

Employee Network, Inc. - EAP & Work Life Services:

Phone and Hours:
1.888.420.1888
24 hours a day, 7 days a week

Website
www.mybalanceworks.com

Information and Appeals:
Employee Network, Inc.
1040 Vestal Parkway East
Vestal, New York 13850

Employee Service Center (ESC)

Phone:
1.888.627.7472

Fax:
1.513.983.1050

Hours:
8:00 A.M. to 6:00 P.M. Eastern time, Monday - Friday

External Address:
Procter & Gamble
Employee Service Center
P.O. Box 5511
Cincinnati, OH 45201-5511

Internal Address:
P&G Benefits Department
IBM Global Park - Costa Rica

HIPAA Administrator

Phone:
1.888.627.7472

Fax:
1.513.983.1050

Hours:
8:00 A.M. to 6:00 P.M. Eastern time, Monday - Friday

External Address:
Procter & Gamble
Employee Service Center
P.O. Box 5511
Cincinnati, OH 45201-5511

Internal Address:
P&G Benefits Department
IBM Global Park - Costa Rica

Healthcare Benefits Manager

Healthcare Benefits Manager
The Procter & Gamble Company
2 Procter & Gamble Plaza, TE-3 Box 4A
Cincinnati, OH 45202

For Active Plans, mark the envelope: Attn: Active Employees

Humana:

Phone and Hours:
1.513.357.6900 or 1.800.357.6900 - Service (24-hour emergency access)
1.866.217.2242 - Pre-authorization Center (24-hour emergency access)
8:00 A.M. to 7:00 P.M. (EST), Monday - Friday

Website: *pg.humana.com*

Claims Address - Medical:
Humana Claims Office
P.O. Box 14610
Lexington, KY 40512-4610

Appeals Address - Medical:
Humana of Ohio Grievance and Appeals
P.O. Box 14618
Lexington, KY 40512-4618

United Behavioral Health Solutions - EAP & Work Life Services:

Phone and Hours:
1.866.309.8545 (toll free)
24 hours, 7 days a week

Website: *Liveandworkwell.com*
Access Code:pg

Claims Address:
OptumHealth Behavioral Solutions by UBH
P.O. Box 740800
Atlanta, GA 30374-0800

Appeals Address:
United Behavioral Health Appeals Dept.
100 East Penn Square
Philadelphia, PA 19107

UnitedHealthcare Medical Services:

Phone and Hours:
1.800.638.2801 - Medical Claims/Customer Service (includes pre-authorization)
8:00 A.M. to 11:00 P.M. (EST), Monday - Friday

Website: *www.myuhc.com*

Claims Address:
UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

Appeals Address:
UnitedHealthcare Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

UnitedHealthcare Retail and Home Delivery Prescription Plan Information (administered by Medco Health Solutions, Inc.):

Phone and Hours:
1.800.842.2038 Retail Prescriptions
1.800.473.3455 Home Delivery Prescriptions
1.800.753.2851 Physician # for Prior Authorization Approval
8:00 A.M. to 7:00 P.M. (EST), Monday - Friday

Website: *www.myuhc.com*

Retail Prescription Claims Address:
UnitedHealthcare Pharmacy Network
P.O. Box 2096
Lee's Summit, MO 64063-7096

Retail Prescription Appeals Address:
UnitedHealthcare Pharmacy Network
P.O. Box 2096
Lee's Summit, MO 64063-7096

Coordination of Benefits Claims Address:
UnitedHealthcare Pharmacy Network
P.O. Box 2097
Lee's Summit, MO 64063-7097

Home Delivery Prescription Claims Address (Mail Order Facility)::
UnitedHealthcare Pharmacy Network
P.O. Box 747000
Cincinnati, OH 45274-7000

Home Delivery Appeals Address:
UnitedHealthcare Pharmacy Network
Procter & Gamble Appeals Committee P.O. Box 747000
Cincinnati, OH 45274-7000

UnitedHealthcare Specialty Pharmacy Services:

Phone and Hours:
1.877.287.1234
1.877.287.7226
8:00 A.M. to 7:00 P.M. (EST), Monday - Friday

P&G U.S. Healthcare Plan Carriers

2010 Healthcare Carrier Matrix			
Group/Sites	**Medical**	**Prescription**	**EAP**
Albany	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Alexandria	*UnitedHealthCare*	*UnitedHealthCare*	*United Behavioral Health*
Andover	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Auburn	*Anthem BC/BS or UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Augusta	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Avenel	*UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Bethel	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Boston/South Boston	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Box Elder	*Humana or UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Cape Girardeau	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Clairol Corp & Mfg	*UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Cleveland	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Devan Warehouse	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Dover	*Anthem BC/BS*	*Caremark*	*Employee Network, Inc. (ENI)*
Duracell Eng. Svc Center	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
CBD, Sales & Closed Sites	*Humana or UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Garrity	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
GO, All Tech Centers & Cincinnati Sites	*Humana or UnitedHealthCare*	*Caremark*	*Concern Plus*
Green Bay	*UnitedHealthCare*	*Caremark*	*Employee Network, Inc. (ENI)*
Greensboro	*UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Hunt Valley	*Anthem BC/BS*	*UnitedHealthCare*	*United Behavioral Health*
Iams Aurora	*Anthem BC/BS*	*UnitedHealthCare*	*United Behavioral Health*
Iams Henderson	*UnitedHealthCare*	*UnitedHealthCare*	*United Behavioral Health*
Iams Leipsic	*Anthem BC/BS*	*UnitedHealthCare*	*United Behavioral Health*
Iams Lewisburg Plant & R&D	*Humana or UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Iams Russelville	*UnitedHealthCare*	*UnitedHealthCare*	*United Behavioral Health*
Iowa City & Iowa City Oral B	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Jackson	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Kansas City	*Anthem BC/BS or UnitedHealthCare*	*Caremark*	*Employee Network, Inc. (ENI)*
Lagrange	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Lancaster	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Lima	*Anthem BC/BS*	*Caremark*	*Concern Plus*

Mehoopany	*Anthem BC/BS*	*Caremark*	*Employee Network, Inc. (ENI)*
Needham	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
North Chicago	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Oxnard	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*
Phoenix	*UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Sacramento	*UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Wella Prestige & DDF	*UnitedHealthCare*	*Caremark*	*United Behavioral Health*
Wella Professional (All sites)	*Anthem BC/BS*	*Caremark*	*United Behavioral Health*

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